EXAMINING THE INFLUENCE OF THE PATIENT DECLARATION OF VALUES ON HOSPITAL POLICIES AND PRACTICES

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Abstract

The purpose of this study was to explore how a leading Ontario hospital operationalizes their Patient Declaration of Values (PDoV) in policy and in practice. This was a single case study, which took place in a leading patient-centred Ontario hospital. The study included 18 individual interviews with employees and patient experience advisors, as well as, document analysis of strategic planning reports (n=10). Five themes emerged: (1) setting the stage, (2) inspiring change, (3) organizational structures, (4) organizational and environmental barriers, and (5) reflection and improvement. This study has highlighted the role of the PDoV within a leading Ontario hospital. It lends itself to providing a process with core strategies for creating change in an acute health care organization; to embed a culture of patient and family centred care.

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Chapter 1 - Introduction

Patient-centred care (PCC) is not a new concept; however in recent years it has garnered increasing attention in the research literature and practice environment. Balint (1957) introduced the concept over 50 years ago in response to the biomedical model of care. The biomedical model focused solely on disease, and failed to encompass the whole person's health state, by omitting psychological and social components of disease (Dawood, 2005). The extensive focus on PCC in the literature and in practice over the past 15 years has helped to foster health care environments where patients act as partners in their care, and are provided with relevant information to make their own decisions (Dawood, 2005). This ensures that the care approach encompasses the whole person's health (Dawood, 2005). The Ontario government created the Excellent Care for All Act (ECFAA) in 2010 for a number of reasons including, but not limited to: improved PCC, transparency, accountability, and motivation for quality in health care (Matthews, 2010). The ECFAA was created with the mandatory requirement that Ontario hospitals create a Patient Declaration of Values (PDoV). In theory the PDoV is conceptualized as a way to improve PCC; however, it is not clear how patient value statements are operationalized in hospital policies and practices to truly influence PCC.

This chapter provides an overview of the current health care system structure in regards to efforts to improve quality. It explores the ECFAA with a specific focus on the PDoV to highlight the importance of the current research project.

Health Care in Canada

Health care services in Canada are governed by the Canada Health Act (CHA) (Harrington, Wilson, Rosenberg, & Bell, 2013), introduced in 1984 by the Canadian

Federal government (Madore, 2005). The CHA has five guiding principles: (1) public administration, (2) comprehensiveness, (3) universality, (4) portability, and (5) accessibility (Madore, 2005). These guiding principles ensure the Canadian health care system remains universal, and provides health services based on need, regardless of the ability to pay (Asada & Kephart, 2007; Harrington et al., 2013; Madore, 2005). In 1984, the guiding principles of the CHA began as a condition attached to the funding for Medicare services. Today, they represent both the values underlying the health care system and the conditions the government has attached to funding (Romanow, 2002). In 2002, a Canadian public opinion survey demonstrated that the majority of Canadians are committed to health care equity, and have accepted a vision of social justice that views health care as a fundamental human right (Axworthy & Spiegel, 2002).

In Canada, health care services are publicly funded (Sutcliffe, 2011). Funding is distributed through 10 provincial and three territorial health insurance plans (Butler, 2009; Noseworthy, 2011; Storch, 2005). A single-payer system, where the government pays for health care costs as opposed to private insurers, is appealing to the public as it is said to be more cost-effective, administratively cheaper to run, and results in better access to care for those most in need (Flood, 2009). However, the delivery of health care in Canada has changed dramatically over the past 10 years, and can now be described as one of abundance (Collier, 2010). This is due to increases in health care spending and demand for services (Collier, 2010), though this has not always translated into high quality health services.

In 1999, Canada spent $86 billion on health care, 9.2% of the GDP (Evans, 2000). Eight years later in 2007, 10.1% of the GDP was spent on health care, yielding $3,895 in

health care costs per Canadian resident (Noseworthy, 2011; Storch, 2005). In 2008, Canada invested $172 billion in health care, an increase of 60% in the last 10 years. This can be attributed to: tailored drug therapies, diagnostic technology, training of health care professionals, and increases in medical and nursing school admissions (Collier, 2010). In Ontario, health care spending accounted for just over 30% of the provincial budget in 1981/82, whereas in 2004/05, it accounted for 45% of the provincial budget (Dhalla, 2007). Assuming that this trend continues, it is projected that health care related costs increase to 55% of the provincial budget by the year 2025 (Dhalla, 2007). Health care related costs are attributed to: more aggressive diseases, sicker and more complex patients, and increasing demands for resources (i.e., drug regimens, diagnostic testing, training of health care professionals) (Hébert, 2010a).

As spending continues to increase every year in Canada, the sustainability of such a system is in question (Butler, 2009; Dhalla, 2007; Noseworthy, 2011; Storch, 2005; Vogel, 2011). It is clear that billions of dollars are invested into health care annually (Butler, 2009); however, more spending on health care has not necessarily led to better health outcomes or greater efficiencies and effectiveness in the health care system (Noseworthy, 2011). According to a public opinion survey, the Canadian Medical Association (CMA) (2011) found that 1/3 of the Canadians surveyed reported receiving poor health care services, with 46% of those complaints related to quality of care received (CMA, 2011). In 2007, 85.7% of Canadians surveyed indicated that they were somewhat satisfied or very satisfied with the health care system (Employment and Social Development Canada, 2014). Despite the increasing health care costs this number has remained stable since 2000, demonstrating that increase in costs does not necessarily

mean an increase in patient satisfaction with health services (Employment an Social Development Canada, 2014). This unsustainable model of spending and recognition of gaps in health service delivery has been an impetus to improve the quality of health care in Canada. This is not unique to the Canadian environment as it is clear many countries (i.e., United States, Netherlands, Australia) continue to look for better ways to deliver service, in order to create a better patient experience (IHI, 2014a; IOM, 2001).

In order to find a solution to the unsustainable health care spending in Canada, it has been outlined that leaders in health care organizations need to modify the practices and attitudes that have led to the creation of a wasteful system, that does not do enough to prevent illness or promote overall health (Joynt & Jha, 2012; Hébert et al., 2011). Hébert et al. (2011) suggest that focusing on high-quality health care will drive the changes necessary to make Canada's health system both cost-effective and sustainable. According to Hébert (2010a), the Canadian health care system needs to adopt the pursuit for excellence in quality, by generating new innovations which will lend to: improved outcomes, health care quality, and satisfaction with health services among Canadians.

Health Care Quality

Achieving high quality care is necessary for reducing mortality, morbidity, and excess costs (Collier, 2010). However, the pursuit of quality in health care is a complex phenomenon due to the numerous health professionals, various departments and services, together with the overall complexity of the individual needs of patients. There is neither a standard definition nor established quality measures that are agreed upon by all key policy makers and leaders (Collier, 2010; Lin, Durbin, & Goldbloom, 2010). This makes

it difficult to capture and quantify what quality truly means to both the populations (e.g., patients) and leaders.

The most commonly cited definition of health care quality (Baker, Denis, Pomey, MacIntosh-Murray, 2010; Crema & Verbano, 2013) is that of Lohr (1990), who described quality as, "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (p.21). Dimensions of quality in health care are defined as the scope or importance of an issue, and are used to guide efforts and measureable outcomes in health care (WHO, 2006).

Although health services in Canada are governed by the CHA, each of the 10 provinces and three territories are responsible for the governance of those services. For this reason, the definition of quality, and the associated initiatives vary, and are specific to the context of each province. For instance, British Columbia developed the BC Health Quality Matrix, which is a guide that focuses on five dimensions of quality for the patient/client experience (i.e., acceptability, appropriateness, accessibility, safety, effectiveness), two dimensions of quality to measure performance of the system (i.e., equity and efficiency), and four areas of care (i.e., staying healthy, getting better, living with illness or disability, and coping with end of life) (BC Patient Safety & Quality Council, 2008). Table 1 highlights the dimensions of quality as indicated by the Institute for Medicine (IOM) (2001) and Health Quality Ontario (HQO) (2012). The IOM (2001) were the founders of quality dimensions in health care, whereas HQO adapted these quality dimensions for use in the Ontario health care context.

Table 1
Quality Dimensions (HQO, 2012; IOM, 2001)

Quality Dimensions	IOM (2001)	HQO (2012)
Safe	Avoid injury to patients from the care that is intended to help them	People should not be harmed by an accident or mistake when they receive care
Effective	Provide services based on scientific knowledge to all who could benefit and refrain from providing services to those not likely to benefit	People should receive care that works and that is based on the best available scientific information
Efficient	Avoid waste	The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time, ideas, and information
Patient-Centred	Provide care that is respectful of and responsive to individual patient preferences	Health care providers should offer services in a way that is sensitive to an individual's needs and preferences
Timely	Reduce waits and harmful delays	
Equitable	Provide care that does not vary in quality because of personal characteristics	People should receive the same quality of care regardless of who they are and where they live
Accessible		People should be able to receive the right care at the right time in the right setting by the right health care provider
Appropriately Resourced		The health system should have enough qualified providers, funding, information, equipment, supplies, and facilities to look after people's health needs
Integrated		All parts of the health system should be organized, connected,

	and work with one another to provide high-quality care
Focused on population health	The health system should work to prevent sickness and improve the health of the people of Ontario

Collier (2010) indicates that hospitals should use these quality dimensions to develop measures that can be publicly released, in order to increase transparency and allow hospitals to be accountable for underperformance. Focusing on the dimensions of quality will drive the changes that are needed to make Canada's health care system cost-effective and sustainable for future generations (Frakt, 2014; Hébert et al., 2011). In hospitals around the world, quality improvement and health lean management practices have been adopted to improve the quality of health services patients receive (Crema & Verbaro, 2013). A variety of managerial techniques, tools, and practices are being used to reduce errors, and ensure high quality of care and patient safety (Crema & Verbaro, 2013). Quality improvement strategies are showing promise and helping to impact health care improvements in the system (Taylor, McNicholas, Nicolay, Darzi, Bell, & Reed, 2014). This can be seen through the multiple organizations that are promoting and encouraging the adoption of quality improvement initiatives in health care (AHRQ, 2011; HQO, 2012; IHI, 2014b).

Priority setting is a challenge for health systems around the world. Decision-makers struggle with determining how resources should be used to provide high quality patient care services in a sustainable way (Sibbald, Gibson, Singer, Upshur, & Martin, 2010). Both consumers and funders in Canada are demanding greater transparency and accountability for how limited health resources are used to meet health system goals

(Sibbald et al., 2010). This is one of the main reasons the Ontario government developed the ECFAA.

Excellent Care for All Act, 2010

Over the course of the last decade, hospitals in Ontario have been faced with difficult choices in regards to priority setting, allocation of resources, and providing quality services to the communities they serve (Born & Laupacis, 2012). Public engagement in health services delivery and structure is especially important for four main reasons (Bruni, Laupacis, & Martin, 2008): (1) the community is the main funder and user of the health care system (Born & Laupacis, 2012), (2) the community should be involved when important decisions are made to keep with democratic principles (Maioni, 2010), (3) community involvement in decision-making offers valuable insight into community values (Born & Laupacis, 2012), and (4) empowering the community to provide feedback in health care will help improve public trust and confidence (Bruni et al., 2008).

In response to the need for public engagement and quality in health care, the Ontario government developed the ECFAA that was passed in legislature on June 8, 2010 (Matthews, 2010). The ECFAA was developed with the patient at the forefront of the delivery system, with the intent that improving quality and value in Ontario's health care system would lend to better health outcomes (Kutty, Ladak, Muskat, Paul, & Orchard, 2012; Matthews, 2010). This would in turn lead to improvements and sustainability in the health care system. The ECFAA enforces the obligations of the Act in Ontario hospitals; however it will be translated and mandated in other health care organizations (i.e., long-term care, community health centres) over the next few years (Matthews, 2010).

As per the ECFAA, Health Quality Ontario (HQO) is the third party organization that is responsible for monitoring compliance of the Act. The functions of HQO are to: (a) monitor and report to the people of Ontario on access to publicly funded health services, health human resources in publicly funded health services, consumer and population health status, and health system outcomes, (b) to support continuous quality improvement, and (c) to promote health care that is supported by best available scientific evidence. Section five of the ECFAA requires HQO to deliver a yearly report to the minister on the state of the health system in Ontario (Matthew, 2010).

The ECFAA imposes six obligations to Ontario hospitals: (1) establish a quality committee, (2) conduct satisfaction surveys of patients and patients' caregivers as well as employees and staff within the hospital, (3) establish a patient relations process, (4) prepare a quality improvement plan which sets out performance improvement targets, (5) ensure executive compensation is tied to the performance improvement targets set out in the quality improvement plan, and (6) publish a PDoV after seeking public consultation (Matthews, 2010). Appendix A further explains the obligations of the ECFAA.

In the only empirical study addressing the ECFAA, Baker and MacIntosh-Murray (2012) examined how the Act influenced Ontario health care governance practices relating to quality and safety. They found that the mandate helped organizations that were not already pursuing the quality agenda (Baker & MacIntosh-Murray, 2012). Furthermore, the ECFAA had an impact on raising the profile of quality of care and patient safety issues for the Boards of Ontario hospitals (Baker & MacIntosh-Murray, 2012). Though this study had important implications for health care in Ontario, the researchers only interviewed the boards of five Ontario health care organizations that

were leaders in quality and safety. It did not ask staff to address how they viewed the operationalization of the ECFAA at the font lines. Additionally, the study did not address whether the PDoV, as part of this Act, has in fact influenced a change in practice or behaviours, as they relate to the PCC purposes of this Act.

The ECFAA has been seen as an important step in creating high-quality care in Ontario hospitals focused on PCC. It has helped to align activities with the core work of hospitals (Baker & MacIntosh-Murray, 2012). As the ECFAA is a fairly new mandate, there is limited research and empirical evidence to support the outcomes and benefits that this mandate has fostered. For this reason, further research on the implications of the ECFAA needs to be conducted.

Patient Declaration of Values

As per Bill-46 of the ECFAA (2010), every Ontario hospital was required to have a PDoV that was created through consultation with the public (Matthews, 2010). In order to comply with the PDoV section of the Act, the PDoV must be: (a) developed in consultation with the public, (b) the public can be defined by patients, their caregivers, and stakeholders, (c) the consultation process needed to be documented with reasonable detail about the people that were consulted, and the methods of data collection and analysis that were used, (d) the PDoV needs to be appropriately named, and made publicly available, and (e) the PDoV needs to be distinguished from other organizational statements, such as the mission, vision, and values (MOHLTC, 2010). Furthermore, within 12 months of becoming subject to this section within the ECFAA, the hospital was required to finalize the PDoV as per the requirements in the Act (Matthews, 2010). Therefore, all hospitals in Ontario were required to have the process initiated by

December 8th, 2010 and have the PDoV available to the public by June 8th, 2011 (MOHLTC, 2010). Should an organization violate any of the regulations as set out by the ECFAA, a maximum of $25,000 can be fined, as well as executive compensation tied to organizations meeting their goals as set out in the quality improvement plans (Matthews, 2010).

The PDoV is anticipated to be a link to the other components of the ECFAA as seen below. The PDoV is reflected in the patient relations process, which lends to the quality improvement plan (Figure 1).

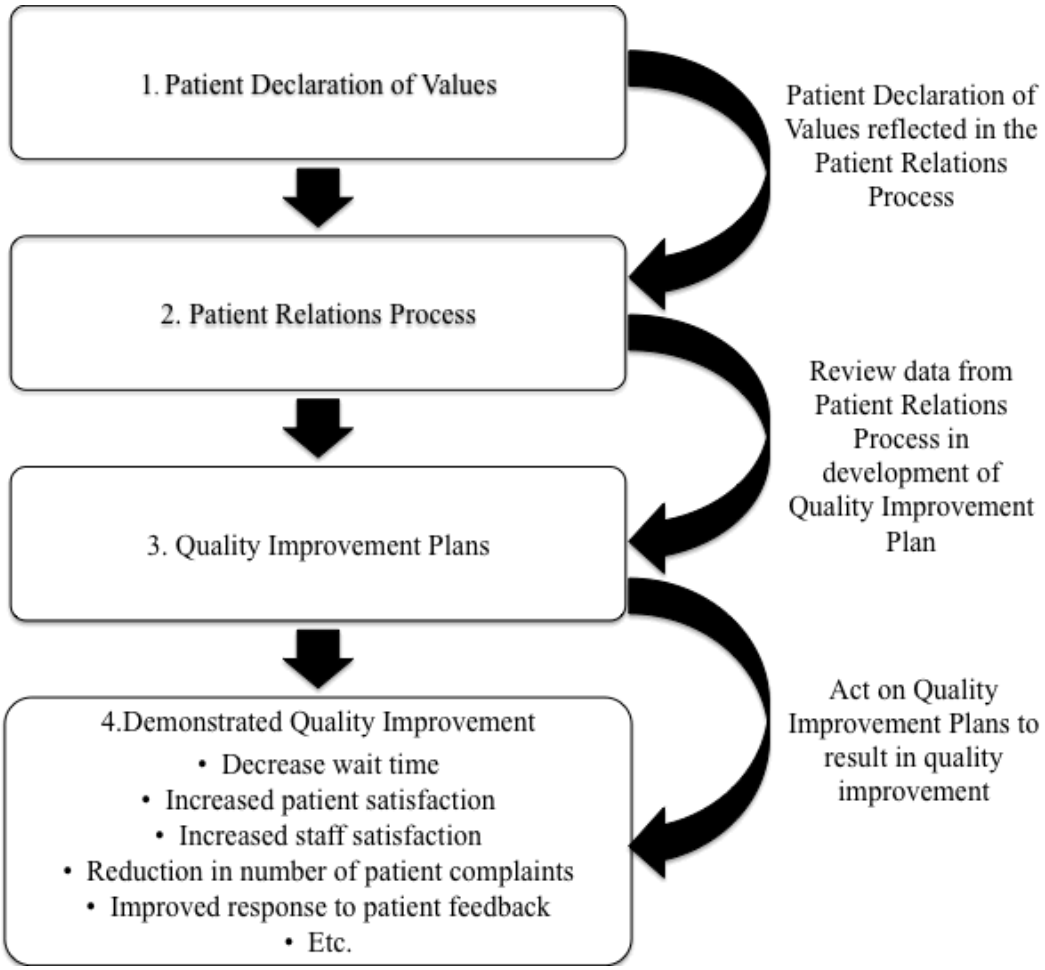

Figure 1. The Patient Declaration of Values in relation to other components of the ECFAA (MOHLTC, 2010).

The PDoV is mandated as it is conceptualized as a way to help hospitals to continue to put patients first and move toward a PCC approach. It helps to clarify what Ontarians can expect from their health care organization (MOHLTC, 2010). The public consultation process, for the development of the PDoV, is viewed as a way to help strengthen the hospital's organizational focus and accountability for delivering high quality patient care (MOHLTC, 2010). However, it is unclear from the existing literature and a thorough search of the MOHLTC and Health Quality Ontario websites as to whether this consultation process was monitored.

Research Gap

In order to improve health services in Ontario through a patient-centred approach, the Ontario government adopted the ECFAA. However, to date no research has examined whether having statements about patient values is in fact linked to hospital policies and practices, which in turn would conceptually improve the quality of health services and patient health outcomes. We are left to question whether Ontario hospitals have referred to and utilized the PDoV to inform policies and practices to improve their PCC approaches. Therefore, the purpose of this research project was to explore how a leading patient-centred Ontario hospital operationalized their Patient Declaration of Values statement in policy and practice.

The current research project reviews literature organizational culture, value statements and PCC literature in chapter 2, to develop a conceptual framework for this project. In chapter 3, the methodological approach for the current research project is explained, followed by the results, which are presented in chapter 4. The results of the current study lend to the development of a patient and family centred process with core

strategies, which are described in chapter 5. Chapter 6 explains how the outlined process in chapter 5 can be utilized by other acute health care organizations, to become high performing health care organizations in patient and family centred care.

Chapter 2 – Literature Review

The PDoV was developed in 2010 as a way to ensure that hospitals continue to ensure that patients are central to decision-making, and commit to moving towards a PCC approach to care. As these values are stated in the PDoV, this provides clarity as to what Ontarians can expect from their health care organization (MOHLTC, 2010). This initiative allows patients to attribute values to their care, and in theory requires hospitals to be accountable to their patient's values.

In 2011, the Canadian Medical Association conducted a survey to understand Canadian perceptions of the health care system. They found that 86% and 82% of Canadians surveyed agreed that a patient health charter, such as a PDoV, outlining patient rights and responsibilities would improve the quality of health services and could make the health care system more efficient. Furthermore, the majority of Canadians surveyed supported the idea of a charter moving beyond just communicating patient rights and responsibilities and becoming a guarantee of service. The Canadians surveyed believed that patient value statements would help to shorten wait times, increase quality of care, and allow for access to health care when needed (CMA, 2011).

As seen throughout the literature, the PDoV could be viewed as an artifact of the organizational culture (Schein, 2010), which requires further operationalization in the practice environment in order to become a truly valued part of the way that work is done. However, due to the lack of guidance and empirical evidence on how to formulate and disseminate the value statements, specifically the PDoV in the health care setting, there is a gap in how this process is understood. For this reason, it is possible that value statements are unable to move past the first level of culture into the values and behaviours

of the organizational, thus only remaining artifacts (Schein, 2010). In order to operationalize patient value statements into patient-centred behaviours, structures and practices need to be in place to embed these values into the organizational culture, allowing them to be reflected in practice. However, there is very little evidence found in the literature to support how these statements are operationalized in the practice setting to influence behaviours, and within the overarching organizational culture to become more patient-centred.

The current chapter provides an overview of organizational culture and value statements from both the business and health care literature, which is then linked to research in PCC. Furthermore, this chapter highlights the gap in the current scientific literature and presents the research question and objectives that guided the current research project.

Organizational Culture

The notion of culture associated with organizations became popular in the 1980's, as management experts indicated that organizational culture was important in the management of organizational performance (Kaufman & McCaughan, 2013; Schein, 2004). Organizational culture can be defined as a set of attitudes, beliefs, customs, values, and practices that are shared by a group (Alvesson, 2002; Ashkanasy, Wilderom, & Peterson, 2000). In its most basic form, organizational culture is described as, "the way we do things around here" (Carroll & Quijada, 2004; Fitzgerald & Desjardins, 2004). Schein (1990) describes organizational culture as: "(a) a pattern of basic assumptions, (b) invested, discovered, or developed by a given group, (c) as it learns to cope with its problems of external adaptation and internal integration, (d) that has worked

well enough to be considered valid, and therefore (e) is to be taught to new members as the (f) correct way to perceive, think, and feel in relation to those problems" (p.111). This framework is important for the current study as it allows for a deeper understanding and grounding of the application of patient value statements in the practice environment.

Organizational culture is unique as it is the invisible architecture of the organization (Tye, 2011), and can be used to explain why an organization focuses on certain priorities (Zhou, Bundorf, Chang, Huang, & Xue, 2013). It provides a conceptual lens through which to examine the meaning and experiences associated with an organization (Knapp & Yu, 1999; Mills & Hoeber, 2013). It is made up of traditions, customs, practices, and habits that characterize the organization and establish behavioural expectations for employees (Kauffman & McCaughan, 2013; Tye, 2011). Schein (1990, 2010) indicates that there are three levels of culture: (1) artifacts, (2) espoused values, and (3) assumptions. Figure 2 illustrates the levels of organizational culture as outlined by Schein (Schein, 2010).

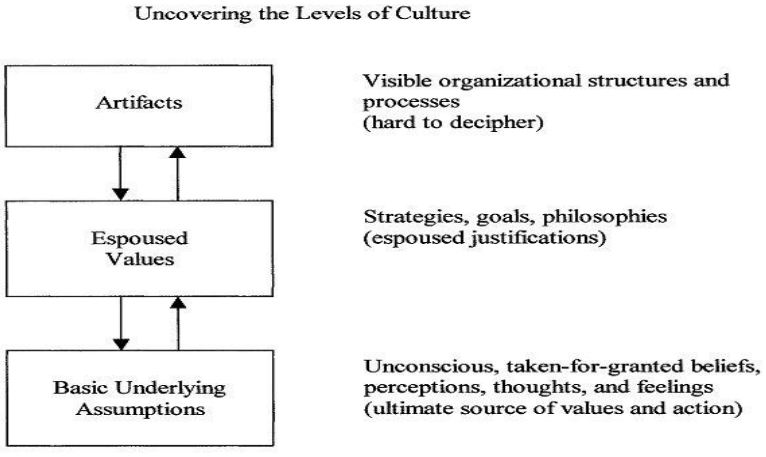

Figure 2. Schein's (2010) Three Levels of Organizational Culture.

Artifacts. Artifacts are the surface level of the organization (Carroll & Quijada, 2004; Schein, 2010). These are the elements of the organization that can be seen and heard when you meet a new group with an unfamiliar culture (Schein, 2010). Artifacts include visible products of an organization including: architecture of the physical environment, language, technology and products, artistic creations, style, clothing and manners of address, emotional displays, myths and stories told about the organization, published list of values, and observable rituals and ceremonies (Kaufman & McCaughan, 2013; Mills & Hoeber, 2013; Schein, 2010; Sproat, 2001; Tye, 2011). Through the use of artifacts, individuals are able to make sense of their environment and understand why things happen (Schein, 2010; Sproat, 2001). Through observation, members of the organization are able to determine which behaviours are expected and rewarded (Mills & Hoeber, 2013; Schein, 2010; Sproat, 2001).

Espoused Beliefs and Values. Schein (2010) indicates that the second level of culture is made up of beliefs and values that are espoused by the members of the organization. The beliefs and values can be displayed through mission statements, signs on the walls or administrative speeches about the quality of patient care (Carroll & Quijada, 2004). These beliefs and values are the ideas, goals, values, and aspirations of the organization (Fitzgerald & Desjardins, 2004; Schein, 2010). They promote the ideologies of the employees and the rationalization of their behaviours (Fitzgerald & Desjardins, 2004; Schein, 2010). While values and beliefs may sometimes be invisible, they are of great importance as the situations that are derived from them can be positive, where it can promote high standards of care, or it can be negative, where it can result in poor standards of care (Schein, 2004).

Assumptions. The third, and deepest level of organizational culture is the basic underlying assumptions (Carroll & Quijada, 2004; Schein, 2010). Assumptions develop when beliefs and values are successfully implemented on a continuous basis; a solution to a problem works repeatedly and therefore becomes taken for granted. It becomes the normal action or reaction to a situation. The solution becomes so taken for granted that there is often very little variation within a social unit (Schein, 2010). This level of culture is extremely important for understanding why things happen or fail to happen (Carroll & Quijada, 2004). Assumptions are unconscious beliefs and values, which determine behaviour, perception, thought, and feeling (Schein, 2010). Basic assumptions tend to be non-confrontable and non-debatable, thus difficult to change in organizations (Schein, 2010).

Organizational Subculture

All organizations undergo a process of differentiation as they grow (Schein, 2004). As these groups grow and become more stable they develop a history of their own and become cultural units (Schein, 2004). These are often referred to as subcultures of the organization, which are reported to be the result of shared assumptions among a functional group of individuals (Schein, 2010). Subcultures generally emerge for five main reasons: (1) functional/occupational differentiation, (2) geographical decentralization, (3) differentiation by product, market or technology, (4) divisionalization, and (5) differentiation by hierarchical level. These subcultures should be analyzed in order to understand the dynamics of how things work (Schein, 2010). For instance, even though individuals will enter the hospital organization and are socialized with the culture of the organization (e.g., the hospital's mission, vision and values), these

individuals will ultimately be shaped by the culture of the unit in the hospital of which they work (e.g., the mission, vision and values of the intensive care unit, or the operation room). This unit within the hospital where the employee works will also have its own culture, thus a subculture of the hospital (Schein, 2004). Subcultures are important in the current study, as the purpose is to understand the operationalization of the PDoV at all levels of the organization. Culture and subculture will ultimately play a role in how it is utilized in policy and in practice.

Culture and Organizational Performance

The concept of culture is multi-layered and complex (Kaufman & McCaughan, 2013). In the literature, organizational culture has been linked to the performance of the organization (Fitzgerald & Desjardins, 2004; Kotter & Heskett, 1997; Schein, 2010). Kotter and Heskett (1997) indicate that strong organizational cultures are high-performing as they: (1) encourage goal alignment, where employees all hold the same goals and values, (2) create an unusual level of motivation among employees, where employees feel good about working for an organization and are loyal, and (3) provide the needed structure and controls without having to rely on formal bureaucracy which can decrease motivation and innovation. Organizations that have weak or poor cultures demonstrate behaviours that are not in line with established values and beliefs, while control is exerted by management/leadership (Schein, 1990). In these types of cultures performance has been seen to decrease (Kotter & Heskett, 1997).

Fitzgerald and Desjardins (2004) compared an organization with clearly defined and communicated behaviours that supported the values of the organization, with an organization that had no defined expected behaviours that supported the organization's

values. The researchers found that clearly defined behaviours that are aligned to organizational values allow employees to be more involved in the organization and participate more regularly in decision-making. This is supported by Jacobs et al. (2013) who found that aspects of performance that are valued within a given culture are enhanced in health care environments exhibiting strong congruence with that culture.

This literature on organizational culture provides a conceptual lens from which to understand how the PDoV must be aligned at all levels of the culture in order to produce positive outcomes of PCC behaviors.

A value statement is an artifact and is the first layer of culture in an organization (Schein, 2010). Artifacts help promote values, which then lead to expected behaviours among staff, shaping the culture of the organization. The PDoV is an artifact of the hospital organizations in Ontario. However, there is no research that examines how the PDoV, as an artifact, evolves into staff values, and ultimately PCC behaviours at the bedside. The following section explores how value statements in organizations have been operationalized to provide expected behaviours, ultimately shaping the high performing culture of the organization.

Value Statements

Although the PDoV is a value statement developed in partnership with the patients, it is not the mission statement of the organization. It could be used as a guide to encourage PCC behaviours among staff, and implement patient values into the policies and practices of the hospital organization. Therefore, an examination of value statements from the business literature provides an understanding of the purpose and use of value

statements in organizations and how this impacts performance. This provides an understanding of how the PDoV can be leveraged within the hospital organization.

Definition. A value statement is not a declaration (e.g. a formal or explicit statement or announcement) or a principle (e.g., an idea that forms the basis of something) (Merriam – Webster, 2014). However, seemingly distinct, a value statement is a term that has appeared to be used interchangeably with mission statement (Bart & Baetz, 1998; Campbell & Yeung, 1991; Ireland & Hitt, 1992; Pearce & David, 1987). Therefore, value statement and mission statement literature will appear throughout this review.

Value statements have been defined as a set of beliefs that represent an organization's thoughts and opinions about themselves (Bart & Baetz, 1998; Campbell, 1997; Fairhurst, Jordan, & Neuwirth, 1997). A value statement should define an organization's business, and attempt to provide a clear picture of what the organization is offering the customer (Brenner, 2007; Ireland & Hitt, 1992; Thompson & Strickland, 1996). In it's most basic form, a value statement should answer, "why do we exist; what is our purpose; what are we trying to accomplish" (Bart, Bontis, & Taggar, 2001)? It is the glue that binds the organization together (Ireland & Hitt, 1992). These values should be used in a way to set up best practices in the organization, as they are used to create emotional support to uplift employees and guide behaviour (Campbell, 1997; Connor & Becker, 1975; Fairhurst et al., 1997; Ireland & Hitt, 1992). Value statements usually address multiple stakeholders such as management, employees, customers/clients, and shareholders (Bart, 1999, 2000; Collins & Porras, 1991; Klemm et al., 1991).

Fairhurst et al. (1997) argued that the absence of a value statement might prevent the organization's identity from taking form. Furthermore, research indicates that the first step to organizational success is articulating the purpose and values (Davison, 1994; Folz, 1993; Kattzenbach & Smith, 1993; Morphew & Hartley, 2006; Pasmore & Mlot, 1994; Wolff, 1993). This is further confirmed by a study by Bain and Company in 1994, which surveyed 500 organizations to understand the use of management tools (Bain & Company, 1999; Bart & Baetz, 1998). Nine of ten organizations surveyed had a mission statement, including values in the past five years (Bain & Company, 1999; Bart & Baetz, 1998). This is important to recognize as articulating patient values in the hospital setting may lead to organizational success (i.e., achieving patient-centred care).

Purpose of Value Statements. Studies articulate that a value statement develops purpose (Campbell, 1992; Klemm et al., 1991; Ireland & Pitt, 1992), expresses organizational tone and climate (Weiss & Piderit, 1999; Wenstøp & Myrmel, 2006), provides a focal point for which employees can identify (Campbell, 1989, 1992; Collins & Porras, 1991; Daniel, 1992; El-Namaki, 1992; Germain & Cooper, 1990; Javidan, 1991; Ireland & Hitt, 1992; Klemm et al., 1991; King & Cleland, 1979; Weiss & Piderit, 1999; Wenstøp & Myrmel, 2006; Wilson, 1992), and guides resource allocation (Ireland & Hitt, 1992; King & Cleland, 1979; Gibson, Newton, & Cochran, 1990). Furthermore, value statements allow the organization to refocus during a crisis (Campbell & Yeung, 1991), create behavioural standards (Bart, 1996a, 1996b; Campbell, 1997; Campbell & Yeung, 1991; Connor & Becker, 1975; Fairhurst et al., 1997; Ireland & Hitt, 1992), and create a balance between the competing interests of stakeholders (Klemm et al., 1991).

Bart (1996b) found that mission statements are generally developed to provide a sense of purpose, to give CEO's greater control, to define behaviour standards, and to enable employees to identify with their organization. Further, mission statements have been found to give greater recognition to the interests of external stakeholders, to inspire employees, to refocus the organization during crisis, to improve the resource allocation process, and are more likely to have an influence on employee behaviour (Bart, 1996b). This is similar to Andersen (2012), who found that employees who identified with the value statements of the organization could relate them to their own experiences in the organization. However, employees who did not identify with the value statement were not able to act according to the decision premise, and thus did not feel as though they were a part of the organization.

The results of these studies help to demonstrate that mission statements create opportunities to accelerate performance; however there are a number of factors that influence the mission-performance relationship including: employee identification, purpose of the statement, content, and satisfaction with the statement. These results provide reason to believe that mission statements, when prepared accordingly, are an advantage for organization. However, there is little research to support how managers translate mission statements into meaningful practices that have the potential to influence performance. This is also the case with patient value statements in the hospital setting.

Value Statements in Health Care Organizations

Bart and Tabone (1998) indicate that there is a particularly important need for mission statements in health care organizations as tightened budgets, new mandates, and changing regulations have created a shift towards managed health care. A well-

articulated mission statement can help hospitals become more efficient, thus enabling them to survive the changing environment (Bart & Tabone, 1998). Although mission statements appear to be beneficial in the health care setting, there has been little practical guidance on how health care administrators should formulate and deploy mission statements (Bart & Tabone, 1999). This information helps to inform how the PDoV can be operationalized into a health care organization effectively.

Bart and Tabone (1998) found that the most common rationales for the hospital mission statements were: providing a common purpose, defining the scope of the hospital's activities, and promoting shared values. Furthermore, the mission statement rationales were positively correlated with measures of hospital performance, and alignment with organizational structures is of key importance to the mission's success. These results are consistent with Bart & Tabone (1999), who found that mission statement content is positively associated with measures of hospital performance. Additionally, these results are consistent with Bart and Hupfer (2004), who found that grand inspiration, benefactors, competitive orientation, and business definition factors in mission statements are positively associated with various behavioural, financial performance, and mission achievement measures. The results of these studies demonstrate an important relationship between mission statement quality and performance; therefore hospital administrators should be clear and passionate when developing hospital mission statements.

Desmidt, Prinzie, and Heene (2009) indicate that in order to utilize the mission statement in health care, it first needs to be developed using the most appropriate rationales. In order to help the process, the development should not be a top-down

process, but rather a joint organizational effort. The process should not be rigid and formal and the mission statement should be distinguished by creativity. These findings are consistent with a study conducted by Bart and Tabone (2000), who found that the stakeholders involved in the process, the process style, the communication of the mission statement, and the methods used to disseminate the mission statement, have an impact on the adoption of a mission statement. These results are important to consider when understanding the operationalization of the PDoV in the hospital setting.

Abdelhadi and Drach-Zahavy (2011) conducted a study on ward climate and PCC behaviours. The nurses in this study found that the creation of a value statement for their ward helped to facilitate a service climate, and thus improved nurse engagement and PCC behaviours. St George Hospital in Sydney, Australia, developed a nursing philosophy for their unit where they were able to identify a gap in their values as compared to practice. The nurses identified that although their philosophy demonstrated their core values, their practice did not reflect their philosophy. This allowed the nurses to move towards behaviour changes that were more focused on PCC (Australian Nursing Federation, 2005).

As demonstrated through these research papers, statements of values/mission appear to be important for health care administrators, as it allows them to align important values to employee behaviours. When utilized correctly, patient value statements may have important implications for PCC behaviour in the hospital, as employees are able to relate to and enact the values created by the patients.

Patient Value Statements

Patient value statements have been increasingly adopted in health care organizations in recent years, as it is said to offer a number of PCC benefits to patients. As demonstrated by the Marshall, Kitson, and Zeitz's (2012) study, patients are not familiar with the term PCC; however, they are clearly able to articulate what PCC means to them in terms of aspects that they value in their care. Patients expressed that they wanted to be involved, feel connected, and have the staff be attentive to their needs. This study demonstrates that while patients are not aware of the concept of PCC, they can attribute values that they attach to their care. This displays the importance of patient value statements as an emerging tool used in a number of health care organizations, to promote PCC behaviours among staff. Unfortunately, there is very little evidence found in the literature to support their use in practice. This then provides very little guidance on how hospital administrators should formulate and disseminate these value statements in the practice environment.

In order to understand patient value statements in the practice setting, we need to examine PCC as a behaviour in health care. This will allow an understanding of the role of the PDoV plays in the practice setting.

Patient-Centred Care

The concept of PCC also known as patient-based, person-centred, client-centred, or relationship-centred care is not new (Frampton, Charmel, Guastello, & Planetree, 2013). The paternalistic model of health care, where doctors are regarded as dominant and able to decide what was in the patient's best interest, has been most common in health care (Dawood, 2005; Dieppe & Horne, 2002). In recent years, health care has

moved towards an informed model of care where, ideally patients act as partners, and are provided with relevant information to make their own informed decisions (Dawood, 2005; Dieppe & Horne, 2002; Frampton et al., 2013). PCC has been argued as a basic human right (Foley, 2011), and centers on the concept of "no decision about me, without me" (Kramer et al., 2014).

PCC is a term widely used in health care today that lacks a clear and consistent definition (Dancet et al., 2012; International Alliance of Patients' Organisations, 2007; Kitson, Marshall, Bassett, & Zeitz, 2012). In the literature, PCC has been more commonly studied in the primary care setting (Balint, 1957, 1969; Binnie & Titchen, 1999; Collins, Nicolson, & Brown, 2000; Coulter, 2002; Dawood, 2005; Gill & White, 2004; Greenslade & Jimmieson, 2011; Hekkert et al., 2009; Kitson et al., 2012; Laine & Davidoff, 1986; Lawrence & Kinn, 2011; Levenstein, McCracken, McWhinney, Stewart, & Brown, 1986; Lewin, Skea, Entwistle, Zwarenstein & Dick, 2001; Mead & Bower, 2002; Pelzang, 2010; Stewart et al., 2000; Valade, 2009), as this setting is said to offer more opportunity for informed choice, emotional support, partnership, and an understanding of the person's socio-cultural situation. Further, the majority of the literature on PCC has been focused on health care professionals perspective of PCC (Kitson et al., 2012), which is why most of the definitions are from the health care provider's perspective. A limited number of research projects have focused on the patient's perception of PCC (Marshall et al., 2012). Table 2 presents the different definitions of PCC found in the literature.

Table 2

Definitions of PCC Found in the Literature

Definition	Sources
Entering the patient's world to see the illness through the patient's eyes.	Levenstein et al., 1986; McWhinney, 1989, 1995
Understanding the patient as a unique human being.	Balint, 1969; Binnie & Titchen, 1999; Redman, 2004; Shaller, 2007
Health care as a partnership among practitioners, patients and their families (when appropriate) to ensure that the decisions taken respect the patient and family's wants, needs, and preferences. The patient should receive the education and support required to make decisions and participate in their own care.	Abdelhadi & Drach-Zahavy, 2001; Agency for Health care Research & Quality, 2005; Coulter, 2002; IOM, 2001; Rogers, Kennedy, Nelson, & Robinson, 2005
PCC involves working in partnership with the patient to meet his or her physical, psychological, social, emotional, and spiritual needs. This is a holistic approach to health care, which encourages participation, fosters empowerment, and treats the patient with respect and dignity.	Brown, 1994; Brown, Mace, Dietrich, Knazik, & Schamban, 2008; Carter, 1994; Leplege, Gzil, Cammelli, Lefeve, Pachoud, & Ville, 2007; Titchen, 1996
PCC represents a humanistic, bio-psychosocial perspective in health care. It is the opposite of the biomedical disease-oriented, evidence-based medical approach, as it emphasizes communication between the patient and the care provider. It allows for power sharing, leading to the patient's participation in decision-making based on their needs and preferences.	Balint, Hunt, Joyce, Marinker, & Woodcock, 1970; Bensing, 2000; Laine & Davidoff, 1996; McWhinney, 1981; Mead & Bower, 2000
Health care providers share control of consultations, decisions about the interventions, or the management of health problems with patients, while considering the patient's point of view.	Lewin et al., 2001; Ponte, Colin, Conway et al., 2003
PCC means putting what is best for the patient ahead of what is good for the practice or the practitioner.	Valade, 2009

Research suggests that positive effects occur when people feel empowered, and feel as though they have been heard (Dieppe, Rafferty, & Kitson, 2002; Groene, 2011; Hébert, 2010b; Lawrence & Kinn, 2011; Lovell & Lee, 2012; Mead & Bower, 2002; Pelzhang, 2010; Redfern, McKevitt, & Wolfe, 2006). Patient-centredness is associated with: better adherence to treatment and care plans, increased patient satisfaction, maintenance of a relationship with a specific health care provider (Collins et al., 2000; Greenslade & Jimmieson, 2011; Hekkert et al., 2009), adherence to the health care provider's advice (Collins et al., 2000), better diagnosis and treatment outcomes and fewer complications, a decrease in frequency of hospitalization and length of stay (Hekkert et al., 2009), better recovery and health outcomes, augmentation of tolerance for stress and pain levels, reduced readmission rates, and better seeking of follow-up care (Balik, Conway, Zipperer, & Waton, 2011; Stewart et al., 2000).

Additionally, when PCC is present in health care organizations, it appears that there is a decrease in costs associated with staff turnover, patient recovery, quicker discharge process, reduced length of stay and there is reduced expenditure as there is a decrease in new staff training (Gill & White, 2009; Welch, 2010). Furthermore, PCC has been associated with a positive hospital reputation and high patient satisfaction scores (Gill & White, 2009; Welch, 2010).

Unfortunately, when patients feel that staff do not understand their situation, and they are not involved in their own care, their suffering increases, as they feel mistrusted and rejected by the staff (Wiklund-Gustin, 2011). When PCC is not present in the health care setting, research has shown that patients tend to rate their health status lower, initiate

malpractice suits, and there is an increase in complaint volume (Greenslade & Jimmieson, 2011; Welch, 2010).

Global Patient-Centred Initiatives. In recent years, efforts to expand PCC have increased due to individual champions and their powerful stories of PCC (Frampton et al., 2013). For example, Australia adopted a new national health care accreditation standard, which emphasizes patient and health care professional partnerships. The accrediting body is releasing new guides on strategies for partnering with patients (Frampton et al., 2013). Furthermore, in the United States, the Hospital Consumer Assessment of Health care Providers and Systems (HCAHPS) patient survey is a new tool that attaches a portion of federal reimbursements payments to the quality of the patient experience in each individual hospital (Frampton et al., 2013). In countries around the world, the global health care landscape is slowly changing to further incorporate PCC concepts into organizational policies and practices (Frampton et al., 2013). Although there are many initiatives underway, in countries around the world, more research and evaluation is required to help inform and guide work in this area.

Patient-Centred Care in Practice

As PCC lacks a widely accepted definition, there is no standard set of PCC dimensions, thus the characteristics of this concept tend to vary in different health care settings. Through examination of the literature the National Research Corporation (2014) has indicated that there are eight dimensions of PCC most commonly used in health care representing a goal standard: (1) patient preferences, (2) emotional support, (3) physical comfort, (4) information and education, (5) continuity and transition, (6) coordination of care, (7) access to care and (8) family and friends. Interventions to improve PCC in

practice tend to reflect at least one of the areas listed above. However, most of the current initiatives underway to improve PCC are directed at the health care professional (e.g., changing the way the professional works) and fail to involve the patient (Dieppe et al., 2002).

Gillespie, Florin, and Gillam (2004) looked at how PCC is understood by the clinical, managerial, and lay stakeholders responsible for promoting this agenda, to understand how PCC translates into practice. Through interviews, the researchers found that there was a large disparity in the understanding of PCC in various disciplines, lending to lack of clarity in the policies and practices that needed to be implemented to advance the agenda. As seen in this study, and demonstrated by Dieppe and Horne (2002), PCC is used as a sound bite (e.g., in the media), and needs to be adequately defined in order to move forward policy and practice in health care organizations.

Brown et al. (2008) highlight that in order to implement PCC behaviours in the hospital setting six steps need to occur: "(1) determine the need of PCC, (2) evaluate policies and procedures for PCC principles, (3) establish a unified departmental and hospital philosophy (values), (4) educate staff, (5) institute and modify policies and procedures, and (6) assess the current environment and make modifications" (p.41).

Summary

It appears that organizational culture can be used to understand how value statements may influence the PCC behaviours of staff. If staff are directly engaged with these value statements through policy and practice change, it is possible that they will in turn become part of the way in which they provide care on a regular basis; thus becoming part of the underlying assumptions of the organizational culture. Unfortunately, there is

very little evidence in empirical studies that demonstrate how value statements are used in hospitals to influence behaviour and practice. In terms of the PDoV, there is a lack of research that demonstrates how leaders in the organization disseminate the value statements to staff and patients. Therefore, there is limited evidence to support how the PDoV is translated into PCC behaviours in the practice setting.

Research Question: The research question for the current project was: "How does a leading hospital in patient-centred care in Ontario operationalize the Patient Declaration of Values in policies and practices?" The objectives of this research were to: (a) understand what role the Patient Declaration of Values plays in policy and practice within a leading Ontario hospital and (b) to examine how a leading Ontario hospital has incorporated these values into their overarching organizational structures.

Chapter 3 – Methods

The current chapter outlines the methodological approach for the current study. The paradigm, methodology, data collection methods, data analysis, trustworthiness and ethical considerations are described. Figure 3 presents a summary of the research process.

Figure 3. Overview of Research Methods Process.

Interpretive Paradigm

Interpretive researchers study the multiple realities constructed by people, and the implications of those realities in their lives and in their interactions with others (Patton, 2002). Knowledge is socially constructed though language and interaction; reality is determined through society's cultural and ideological categories (Tracy, 2012). Since the purpose of this research project is to explore how the operationalization of the PDoV influences policy and practices, the interpretive paradigm is directly applicable as individuals in the organization may conceptualize the operationalization of the PDoV differently. Therefore, the interpretive paradigm is well suited to the current project and helped guide the chosen methodological approach, data collection and analysis.

Researcher Reflexivity. Researcher reflexivity is a common practice in qualitative research as it acknowledges the researcher's place in and impact on what is studied (Richard & Morse, 2013). As the researcher in this study, my personal experiences as a friend of a patient have an impact on how I understand and interpret PCC within the acute care environment. From 2011-2014, my friend remained in the Intensive Care Unit of multiple Ontario hospitals; he was in a coma as a result of a diving accident. The clinical care provided by the physicians and employees of the hospital was adequate; however his family and friends struggled to be heard by health care providers leading to extreme dissatisfaction. Through this experience, I began to wonder why patient and family values were not accounted for in the care environment, particularly in hospital policies and practices. For this reason, I wanted to study a leading patient centred

Ontario hospital to understand how they were implementing PCC policies and practices within their organization.

As a friend of a patient who experienced poor PCC within multiple Ontario hospitals, I have come to value PCC within the acute care environment and believe that it must be implemented at all times. Although I value PCC within the hospital, I appreciate that health care organizations are often challenged in providing PCC and for this reason, understanding both the successes and challenges of PCC from the organizational (i.e., hospital) and individual perspective (i.e., employees and patients) will be important to the current research question. It is important to acknowledge that I am not a health care professional and do not work in the acute care environment therefore, I cannot truly relate to the PCC successes and challenges that they face daily in providing this care. Through the participant voices, it is my hope that I will be able to better understand these successes and challenges in an attempt to translate the findings of this research to other hospitals in Ontario, to further improve PCC services for all patients and families.

Qualitative research

Qualitative research allows investigators to study a problem or an issue in-depth, in order to gain a complex and detailed understanding of the phenomenon (Creswell, 2013). To study these problems or issues, qualitative researchers collect data in the natural setting in order to be sensitive to the people or the place under study (Creswell, 2013). The analysis of data is an inductive process, which allows themes and patterns to emerge, thus allowing the voice of the participants to be present in the written report (Creswell, 2013). The qualitative approach was ideally suited to this research project. It allowed for a deeper understanding of the operationalization of the PDoV in policy and

practice, and led to an understanding of the contextual elements that were present within the organization that influenced this process.

Qualitative Research in Health care. Qualitative research in health care is relatively unique, as the pre-dominant approach has been in quantitative methods (Morse, 2012). Medicine has traditionally been concerned with the pathophysiological process rather than with the person (Morse, 2012). For instance, it has generally been more important to develop adequate drugs than to learn about the experience of chronic pain or how a patient copes with that pain in their daily lives (Morse, 2012). In recent years, PCC has become increasingly important in the health care setting, which has led to the emergence of more qualitative approaches found in the research (Morse, 2012). Studies in qualitative health care research enable researchers to record individual events, evaluate care experiences, and group experiences together to identify patterns and theories (Morse, 2012). The outcome of this genre of research is to produce results that are value-laden, subjective and usually beyond the reach of quantification (Morse, 2012). The results are then generally implemented to develop policy or to change practice (Morse, 2012).

Organizational Qualitative Research. Traditionally, quantitative research has been used in organization and management studies; however there has been an increasing interest in the in-depth study of organizations that have been produced from qualitative work (Cassell & Symon, 2004). Qualitative research is commonly used in organizational science research, as the research question usually aims to gather a detailed understanding of the organizational process (Hartley, 2004). Using the qualitative approach allows the researcher to place emphasis on the understanding of the process alongside organizational contexts (Hartley, 2004).

For this reason, in order to study the PDoV and its influence on policies and practices within the hospital, a qualitative approach was taken using a single-case study methodology.

Single Case Study

The single-case study methodology investigates a phenomenon in-depth and within its real-life context, in order to understand the relationship between the phenomenon and the context (Yin, 2009). When using the case study as a methodological approach, the researcher wants to understand a complex social phenomenon (Yin, 2009). This methodology allows the researcher to retain the holistic and meaningful characteristics of real life events (Yin, 2009).

Case studies are widely used in organizational studies (Hartley, 2004). The single-case study was used in the current study, as the aim was to understand the operationalization of the PDoV in a leading Ontario hospital. It was selected as opposed to the multiple-case study, as to accomplish this study in great depth, numerous interviews and analysis of all relevant documentation was required. Future research in this area may want to explore multiple hospitals to compare how each site is using the PDoV in policy and practice. In this case, the multiple-case study approach would have been the appropriate methodology; however due the time constraints and the desire to explore this topic in-depth and at many levels of the organization, a single-case was believed to be ideal.

Agency Site Selection. Aligned to the case study approach, purposeful sampling was used, which is a method of sampling that provides a clear criterion or rationale for the selection of participants and/or places that relate to the research question (Ezzy, 2002;

Patton, 2002; Yin, 2009). Purposive sampling was selected as opposed to snowball, convenience and theoretical sampling as the research question highlights the selection of a leading Ontario hospital. This selection is based on a characteristic as opposed to recommendations from others, a site that was available to the researcher, or a site that fit the emerging theoretical scheme (Richards, & Morse, 2013). The agency identified for this study was selected based on a purposeful sampling technique in order to obtain an information-rich case that was suited to answer the research question (Ezzy, 2002; Patton, 2002; Yin, 2009). This allowed the researcher to accurately depict how the PDoV influenced policies and practices, and how the hospital had incorporated these values into their organization's overarching structure. Studying information-rich cases yields insights and an in-depth understanding, rather than generalizations (Patton, 2002).

In light of the research purpose (Stake, 1995), the agency site selection process had three steps: (1) expert consultation process, (2) verification that the hospital had met the ECFAA PDoV criteria, and (3) letter of invitation to the hospital.

Site Selection Criteria 1. A list of five PCC experts was determined through consultation with the master's student and her supervisor. The criterion for choosing these experts was that: (a) they had been involved in the development or administration of the ECFAA (e.g., staff at Health Quality Ontario), and/or (b) had engaged in the development of PCC approaches at the hospital level either through research, program coordination and implementation, or management and leadership (e.g., staff at the Ontario Hospital Association, researchers). These individuals were sent a letter and a form (Appendix B) asking them to provide a list of three organizations they viewed as leaders in PCC and in the administration of the PDoV. Once they determined the three

organizations that fit the criteria as set out in Table 3, they were requested to rank the organizations from one to three, with one being the most successful organization at the operationalization of PCC and the PDoV in policy and practice.

Table 3
Criteria for Organization Site Selection

a) Is located in Ontario
b) Is viewed by peers as a leader in PCC
c) Has a Patient Declaration of Values
d) Has staff dedicated/accountable to the development of a PCC approach in the organization
e) PCC is a strategic priority
f) Is engaged in many PCC activities such as research, workshops, conferences

Site Selection Criteria 2. In order to comply with the PDoV consultation process, the PDoV must be: (a) developed in consultation with the public, (b) the public can be defined by patients, their caregivers, and stakeholders, (c) the consultation process needs to be documented with reasonable detail about the people that were consulted, and the methods of data collection and analysis that were used, (d) the PDoV needs to be appropriately named, and made publicly available and (e) the PDoV needs to be distinguished from other organizational statements such as the mission, vision, and values (MOHLTC, 2010). In Ontario there are 157 public, private, and specialty psychiatric hospital corporations, which operate out of 239 sites (MOHLTC, 2013). From the returned forms, a master list of the rank order of the organizations was created, and the number of times that each organization appeared on the forms was tabulated. A simple tally of the number of times the organizations appeared on the list was conducted, and the final nomination list of the top ranked organizations by way of the most nominations was created. During the second step, the principal investigator reviewed each hospital identified by the experts and ensured that the nominated hospitals had met the PDoV

criteria set out by the ECFAA. This ensured that the leading hospital in PCC and the administration of the PDoV was selected as the study site. This was done through analysis of each hospital's website using the ECFAA PDoV criteria as outlined above in Table 3.

Site Selection Criteria 3. The organization appearing the greatest number of times and abiding by the ECFAA PDoV guidelines was selected for the study. The nominated agency was contacted with a letter of invitation (Appendix C), asking if they would like to participate in the study. The top ranked hospital agreed to take part in the study.

Setting Description. A North Eastern Ontario hospital nominated by experts as a leader in PCC was selected for this study. This hospital is part of the South East Local Health Integration Network and is an acute care hospital classified in the following categories by the Ontario MOHLTC: (a) general/teaching hospital, (b) cancer care centre, (c) general rehabilitation facility, (d) computerized axial tomography (CTs) availability, (e) magnetic resonance imaging (MRI) availability, and (f) transplantation centre (MOHLTC, 2010).

In 2009/10, the hospital was in a lot of trouble financially, had a poor organizational culture, as well as poor clinical outcomes. The leaders in the organization as well as the employees understood that the culture and performance metrics of the hospital needed to change. The hospital administrators decided that in order to change, they needed the help of their community and embarked on a community engagement process. In 2010, with the input of over 2,000 stakeholders, the hospital developed and launched their 2015 strategy. This provides the context and direction of their efforts to realize the vision of the hospital: "Outstanding Care, Always." The hospital aims to be

top performers and make their vision a reality for every patient, every day through advances in clinical care, knowledge, and leadership. The strategy is not only about imagining the future but "making it happen." This strategy outlines 14 concrete outcomes to be achieved by 2015, where one of the main outcomes is to "engage patients in all aspect of quality, safety, and service improvement initiatives." Specific initiatives that are anticipated to achieve this outcome include: (a) the establishment of a Patient Advisory Council, and patient experience advisor roles, (b) the integration of patient experience advisors into key hospital activities, (c) the adoption of patient-centred communication standards, and (d) the improvement of patient satisfaction.

Agency and Sample Size. Yin (2009) indicates that an appropriate sample size for a qualitative study is one that adequately answers the research question. The number of participants often becomes obvious as the study progresses, when new themes and categories stop emerging from the data (Marshall, 1996). Saturation is assumed when there are no new themes or categories emerging from the data collected (Corbin & Strauss, 2008). Saturated data is rich, full, and complete (Hesse-Bieber & Levy, 2010). The results make sense and do not have gaps (Hesse-Bieber & Levy, 2010).

In order to guide the current project and provide an estimate of the sample size, other research in health care was examined. It is clear that qualitative case study sample sizes vary significantly (Baker & Edwards, 2012). Some sample sizes ranged from 12 to 60 with 30 being the mean, where others had a sample size of one (Baker & Edwards, 2012). This clearly demonstrates that sample size is dependent on the question being asked (Yin, 2009). If the question is very specific, a smaller sample size may be feasible whereas, if the question is less specific more participants may be required to validate the

results (Baker & Edwards, 2012; Yin, 2009). In the current study, 18 interviews with participants were required before case saturation was reached (Yin, 2009). Case saturation was reached, as there were three or four literal replications of the data for the entire case (Yin, 2009). Although there were only one or two participants in each job role, saturation was assumed when no new information emerged from the case as a whole, not specifically for individual job roles. The following section will explain the data collection process and procedures as well as the individuals selected for the study sample.

Data Collection and Procedures. In qualitative research, researchers look to understand the complex interrelationships between variables (Stake, 1995). Case study research is known to use multiple sources of data, as the multiple sources of evidence will help to add credibility to the research (Patton, 2002; Thomas, 2011; Yin, 2009, 2012). In this case document analysis and individual interviews were used, in order to obtain a comprehensive overview of the phenomenon of interest (Yin, 2009, 2012).

Document Analysis. Document analysis is defined as "a research method for making replicable and valid inferences from texts" (Krippendorff, 2013, p.24). Document analysis data can take the form of art, images, maps, sounds, signs, symbols, and records (Krippendorff, 2013). In hospitals, formal documentation can consist of patient medical records, complaint databases, organizational structure documents, and strategic planning documents (Morse, 2012). In this research project, the hospital documents that were analyzed include: strategic planning documents such as the PDoV, the 2015 Action Plan, all patient experience advisor materials, quality improvement plan as well as the last five years summary. These documents were integral to understanding

the PDoV, as it provided insight into the practices and policies of the hospital (Yin, 2009, 2012). All documents listed above were reviewed in order to gain a comprehensive understanding of the operationalization of the PDoV in policy and practice, even if these are simply demonstrated at the artifacts level of the culture. These documents were collected from the hospital website and from the interviewees themselves.

To aid in the data analysis process, a document summary form (Appendix D) was utilized (Krippendorff, 2013; Miles & Huberman, 1994). When doing document analysis documents can be lengthy and need clarifying and summarizing therefore, it was important to obtain the document's significance (Krippendorff, 2013; Miles & Huberman, 1994). This summary form allowed the document to be put in context, while explaining its significance and giving a brief summary (Krippendorff, 2013; Miles & Huberman, 1994).

Document analysis is a rich-source of primary data, as it has a number of strengths: (1) it is a stable source of data, as it can be reviewed repeatedly, (2) it is unobtrusive, as it is not created as a result of the case study, (3) it is exact, as it contains the exact details of a person or an event, and (4) it has broad coverage, as documents cover a long span of time, many events, and many settings (Berg, 2004; Yin, 2009). However, texts do not have a single meaning that can be found, identified or described for what they are, or correlated with states of their sources (Krippendorff, 2013). Documents can be read from multiple perspectives and can have several designations (Krippendorff, 2013). For this reason, document analysis was coupled with individual interviews to allow the multiple perspectives to emerge.

Individual Interviews. Interviews yield direct quotations from people about their experiences, opinions, feelings, and knowledge (Patton, 2002). In-depth interviews allow researchers to ask key respondents about the facts of a matter, as well as their opinions about an event (Yin, 2009). The purpose of the in-depth interview is to obtain a rich, in-depth experiential account of an event or an episode in the life of the participants (Fontana & Frey, 2005). They are used to find emerging patterns from "thick descriptions" of social life recounted by the participants (Hesse-Biber & Leavy, 2010). Similarly, interviews hold some inherent weakness including: (1) possibly distorted responses due to personal bias, (2) lack of awareness, as the interviews can be greatly affected by the emotional state of the participant at the time of the interview, (3) response bias, (4) inaccuracies due to poor recall, (5) reactivity of the interviewer, and (6) reflexivity, the participant gives the interviewer what he/she would like to hear (Patton, 2002; Yin, 2009). The following section outlines how these limitations were minimized in the current study.

In the following study, in-depth interviews were conducted with staff and patients, using a semi-structured interview guide (Yin, 2009) (See appendix E). The semi-structured interview guide is generally used when the researcher uses information that they have gathered to construct questions that are more focused on the research question (Olson, 2010; Seidman, 2013). The questions in the semi-structured interview guide were shaped in a way to allow the participants to share deep opinions and insights on their experience in the hospital, while also ensuring that questions were aligned to theories and concepts as set out in the conceptual framework (i.e., PCC concepts, organization culture,

value statements) (Olson, 2010; Seidman, 2013; Yin, 2009). The interviews resembled a guided conversation, rather than a structured query (Hesse-Biber & Leavy, 2010).

Schrøder (2000) developed a multidimensional model of media reception based on five dimensions: (1) comprehension, (2) discrimination, (3) implementation, (4) motivation, and (5) position. The primary purpose of the model was to provide the researcher with a tool that captured the complexity of readings when analyzing the qualitative reception of data (Schrøder, 2000). Furthermore, the model indicates that individual's subjective experiences are produced from specific situational context (Schrøder, 2000). Andersen (2012) used Schrøder's (2000) multidimensional model for media reception to analyze how employees understand a value statement, allowing detailed insight into the process of employee identification with organizational texts (value statement), and how this identification may fluctuate in various contexts.

Given the context of this study, Schrøder's (2000) five dimensions of the interior reading process were used to develop the interview guide: (a) comprehension – how does the interviewee understand the PDoV text both denotatively and connotatively, (b) discrimination – does the interviewee adopt a critical stance toward the content of the PDoV or does the interviewee perceive it as an unquestionable transparent representation of the social reality within the organization, (c) implementation – how does the interviewee use the content of the PDoV as a point of departure for decision-making in daily work activities, (d) motivation – how motivated is the interviewee and does the interviewee feel a strong or a weak involvement in adoption and utilization of the PDoV, (e) position – what is the interviewee's subjective attitude toward the content of the PDoV and the interviewee's personal experiences within the organization?

The first question of the interview guide was "Have you heard of the PDoV?" If the participant was familiar with the PDoV, the interview continued using the term PDoV. As most employees and patient experience advisors were unfamiliar with the PDoV, it was suggested that the term "patient and family centred care" be use in the interviews with participants. Thus, when the participant indicated that he/she did not know what the PDoV was, the interviewer continued the interview using the term "patient and family centred care." Patient and family centred care (PFCC) is an underlying concept of the PDoV and the research question could still be answered using language similar to that of the organization.

Eighteen participants (N=14 females; N= 4 males) who were employees or patient experience advisors within the hospital were interviewed in January 2015 at the hospital site. Participants included: (a) the CEO (n=1), (b) the PFCC lead (n=1), (c) directors of various programs (n=2), (d) clinical managers of different programs (n=2), (e) a physician (n=1), (f) a nurse practitioner (n=1), (g) nurses (n=2), (h) allied health professionals (n=2), (i) PT/OT (n=2), (j) a maintenance worker (n=1), (k) a porter (n=1), and (l) patient experience advisors (n=2). No other job roles within the hospital were required as the sample represented a holistic picture of the hospital organization. The participants were selected from multiple departments, as the subcultures within the hospital provided different perspectives. Interviewing participants in multiple job roles and from multiple departments within the hospital allowed for maximum variation sampling. This led to results from multiple perspectives, providing a holistic picture of the PDoV in the hospital organization. It was important that the participant felt comfortable during the interview process (Hesse-Biber & Leavy, 2010) therefore, the

interviews were conducted in a private meeting room, and at a time and date that was convenient for the participant (Olson, 2011; Seidman, 2013; Yin, 2009).

Congruent with case study best practice (Yin, 2009), the interviews lasted between 20 to 50 minutes (Hesse-Biber & Leavy, 2010). Participants in leadership positions (n=7) were recruited through the hospital's online "Leadership Organizational Chart". Frontline staff (n=11) were recruited through the PFCC lead, who agreed to provide the researchers with a contact list of 60 frontline staff and patient experience advisors. The researcher, to ensure confidentiality and anonymity, then contacted 11 individuals. Although the participant's informed and voluntary participation was discussed prior to the interview, informed consent (Appendix F) was explained at the time of the interview (Hesse-Biber & Leavy, 2010). The participants were asked to read and sign the informed consent (Appendix F), and were encouraged to ask any questions about the study prior to the start of the interview. The interview was audio recorded, and transcribed during data analysis (Olson, 2010; Seidman, 2013; Yin, 2009). Once the interview was complete, the researcher recorded initial reflections of the interview in a contact summary sheet (Appendix G), in order to inform and ensure correct and accurate data analysis (Hesse-Biber, 2010; Milne & Oberle, 2005).

Data Analysis. During the data collection process researchers begin discerning the meaning of the information through note patterns, trends, possible explanations, and ways of arranging the data (Gagnon, 2010; Yin, 2009, 2012). The first thing that was done was organizing and classifying the data to make it easier to analyze (Gagnon, 2010; Yin, 2009, 2012). The document data was summarized using document summary forms (Appendix D). The document summary forms allowed for the organization and

classification of the data prior to the analysis process (Krippendorff, 2013; Miles & Huberman, 1994). Furthermore, the interviews were audio recorded, and then were transcribed verbatim by a transcription service (Olson, 2010; Yin, 2009, 2012).

The document and interview data were uploaded into the NVivo10 software, which is a computer-assisted qualitative data analysis software (Yin, 2009). This software allowed the researcher to further sort and organize the data prior to analysis (Hesse-Biber & Leavy, 2010; Yin, 2009). Furthermore, these tools helped the researcher code and categorize data that had been collected from the interviews and document analysis process (Yin, 2009). Figure 4 outlines the data analysis process used in the current study.

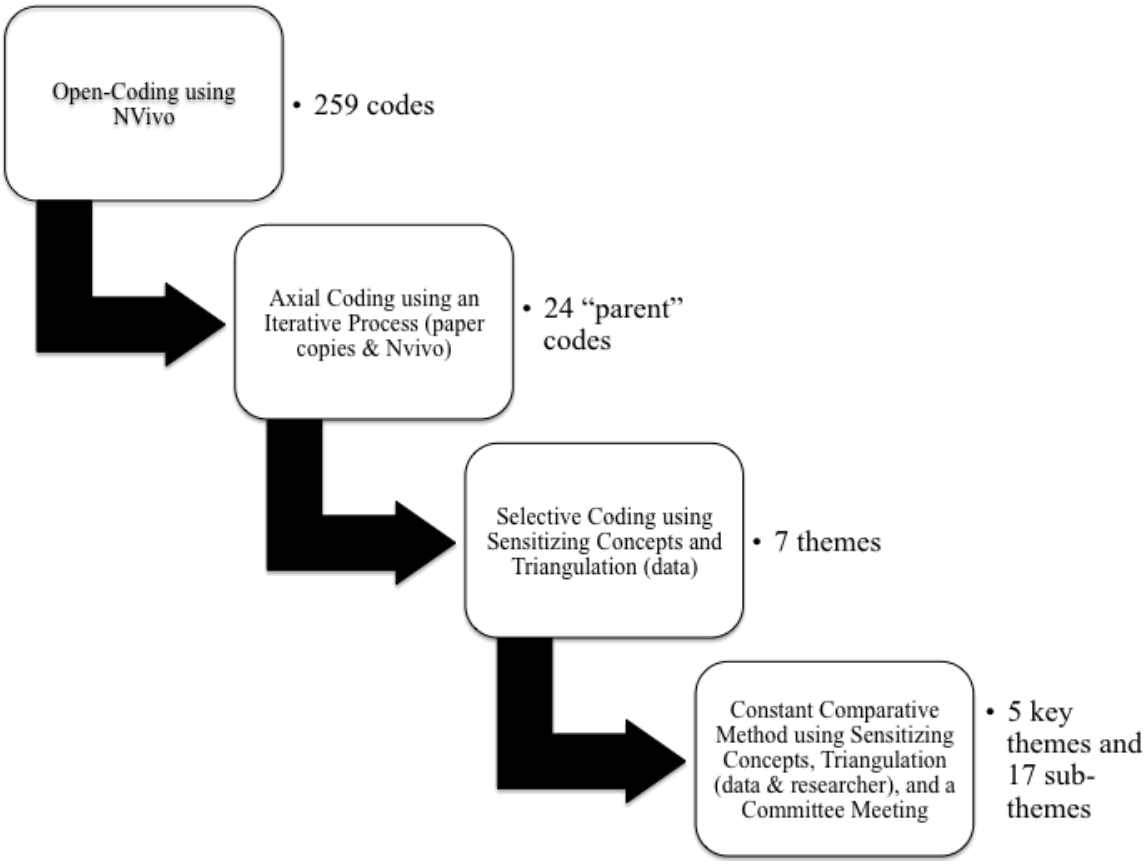

Figure 4. Data Analysis Process.

The document and interview data were analyzed inductively (Ezzy, 2002; Patton, 2002). This means that the patterns, themes, and categories emerged during the analysis, allowing the researcher to code the data by key meaning units, therefore contributing to the development of key themes (Corbin & Strauss, 2008; Patton, 2002). The document data and the transcripts were read thoroughly, line by line, allowing the researcher to attribute key ideas and notes to certain fragments of sentences (Hesse-Biber & Leavy, 2010). This process is called open coding (Patton, 2002). The codes that were given to key ideas in the text data were in vivo, as they are the words spoken by the participants (Olson, 2010). In the current case study, 259 codes emerged during the open-coding process.

Following the open-coding phase of analysis, the researcher began axial coding. This was an iterative process, where the researcher went back and forth between paper copies of the codes and NVivo. The researcher read and re-read segments of sentences attributed to each code, in order to establish relationships between the codes, and determine similarities and differences. During the axial coding process, the codes began to form larger units, also known as "parent" codes. In this case, following the axial coding process, the 259 nodes were grouped into 24 "parent" codes.

The third phase of the analysis process is known as selective coding. As the codes continued to emerge from the data, themes, larger units that include a number of codes began to form (Ezzy, 2002; Patton, 2002). During this phase, sensitizing concepts were used to guide the analysis process. Sensitizing concepts are defined as concepts that offer ways of seeing, organizing and understanding an experience (Patton, 2002). They are a point of departure to study the data (Patton, 2002). The theoretical frameworks in the

current study (i.e., organizational culture, value statements, and PCC) were used as sensitizing concepts, and offered insight on how to group the data into key themes. Further, data triangulation was utilized. The documents analyzed (i.e., PDoV, 2015 strategic plan, patient experience advisor material, the quality improvement plan, and the last five years summary) were used to compare and contrast the findings from the interview data, to ensure that the document content aligned to the interview data. The selective coding process led to the development of seven key themes.

A constant comparative method was employed during the analysis process of this study (Glaser, 1965; Hewitt-Taylor, 2001; Thorne, 2000). The constant comparative method indicates that as incidents emerge, they should be compared against other explanations for similarities and differences (Ezzy, 2002). These comparisons allowed the data to be grouped together and differentiated as themes were identified, and various pieces of data were grouped together (Ezzy, 2002; Yin, 2009). The themes were described repeatedly from different point of views to understand how the event or situation may best be categorized (Yin, 2009). The key themes were then compared to reveal relationships that existed among the themes (Corbin & Strauss, 2008). Using sensitizing concepts, triangulation (data and researcher), and an advisory committee meeting, the seven themes were restructured into five key themes and 17 sub-themes.

Trustworthiness

Qualitative case study inquiry considers four aspects of trustworthiness: credibility, transferability, dependability, and confirmability, to enhance rigour of the data (Yin, 2009, 2012).

Credibility. The credibility of qualitative inquiry is dependent on three elements: (1) rigorous methods for doing fieldwork, (2) credibility of the researcher, and (3) philosophical belief in the value of qualitative inquiry (Patton 2002).

In this study, credibility was managed through data triangulation, researcher triangulation, and member checking with participants. Data triangulation is the notion of collecting information from multiple sources of data, in order to corroborate the same fact or phenomenon (Patton, 2002; Yin, 2009). In the current study individual interviews as well as document analysis were used to understand the PDoV and its influence on policies and practices within the hospital system. The data triangulation occurred, as themes and categories were revisited continuously to examine points of convergence and divergence across the participants in the study. Additionally, interviews were conducted with individuals in multiple health professions, providing a degree of triangulation in the current study.

Researcher triangulation is the process of using multiple analysts to independently analyze the same qualitative data and compare their findings (Patton, 2002). A researcher trained in qualitative data analysis, in addition to the principle investigator, both analyzed the same collected data then compared the findings. Through this process it was clear that the majority of the main themes were similar; however the titles appeared somewhat different between the two researchers. The differences that emerge in the comparison of key themes were discussed and resolved between the two researchers (Patton, 2002). Finally, member checking (Patton, 2002) occurred with the participants following the transcription of the interviews. The individual transcript was emailed to each respective participant. The researcher asked the participant to review the transcript for any errors or

misinterpretations. The participant had the opportunity to remove information that had been said, or add information that was missed. This gave the participants the opportunity to identify whether or not the researcher has properly interpreted their experience (Patton, 2002). The researcher informed the participants that if they did not have any changes to make, a response to the email was not required, and the transcript would be analyzed as is. During the member checking process, four individuals made changes to their respective transcripts.

Transferability. The transferability of qualitative case study research is the extent that the research findings can be applied to other contexts (Gagnon, 2010; Yin, 2009). In case study research transferability is a result of the research design and characteristics of the study (Yin, 2009). In the current study transferability was addressed through: (1) analytic generalization, (2) data collection strategies, and (3) population sample as outlined by Gagnon (2010) and Yin (2009). Analytic generalization is seen when a previously developed theory is used as a template with which to compare the empirical results of the case study (Yin, 2009). In this study PCC, value statement, and organizational culture frameworks were used to compare empirical results of the case study. The PDoV influences policies and practices within the hospital therefore; the results could resemble those of a study in another Ontario hospital. The case selected for this study may have similar characteristics to other hospitals in Ontario; thus the results could be generalized to other hospitals with the same population characteristics (Gagnon, 2010; Yin, 2009).

Dependability. Dependability is the likelihood that research findings are consistent and can be replicated with latter results (Yin, 2009). Dependability is the

notion that if another investigator followed the same procedures as described by an earlier investigator and conducted the same study again, that the researcher should arrive at the same findings and conclusions (Yin, 2009). Thus dependability of the results is largely dependent on the rigorous process of data collection (Yin, 2009).

In order to achieve dependability, this study used a case study database (Yin, 2009). This allowed data collected to be organized and documented (Yin, 2009). There are four ways to develop a case study database: (1) notes: the researcher's notes are likely the largest component of the database and take on a variety of formats (interviews, observations, documents), (2) documents: documents relevant to your case are collected, (3) tabular materials: survey, or quantitative data, and (4) narratives: types of narratives that are produced by the case study researcher upon completion of the data collection (Yin, 2009). In the current study, a document analysis summary (Appendix D) and a contact summary sheet (Appendix G) were used to help with the summary and organization of the data to ensure reliability.

Confirmability. Confirmatibility is the notion that independent researchers will discover the same phenomenon or develop the same constructs if they apply the same worldview and/or methodology in a similar or identical setting (Gagnon, 2010). Confirmability can be achieved through the analysis of the data using a constant comparative method (Gagnon, 2010; Patton, 2002).

In the current study confirmability was achieved through a constant comparative case analysis (Patton, 2002). This process allows the researcher to look for other ways of organizing the data, which may lead to different findings (Patton, 2002; Yin, 2009). This meant thinking about different possibilities and then determining if those possibilities

were supported by the data (Patton, 2002; Yin, 2009). This allowed for further confirmability of the results of the current study.

Ethical considerations

Ethical consideration is an important aspect of any qualitative study. The current study examines issues related to the Research Ethics Board (REB), informed consent and confidentiality.

Research Ethics Board. Qualitative inquiry raises unique ethical issues as it generally involves an emergent and flexible research design, and collects data in the naturalistic setting (Ezzy, 2010; Hammersley & Traianou, 2012; Yin, 2009). The current study received ethical clearance from the Brock University Research Ethics Board (REB) [File # 14-033] (Appendix H). Ethical approval for this study was not required by the hospital organization.

Informed Consent. Human subject protection is an essential aspect of qualitative and case study research (Ezzy, 2010; Hammersley & Traianou, 2012; Kvale & Brinkman, 2009; Yin, 2009). Nearly all case studies study contemporary human affairs therefore, as part of the protection to the participants, it is the researcher's responsibility to conduct the case study with special care and sensitivity (Ezzy, 2010; Hammersley & Traianou, 2012; Kvale & Brinkman, 2009; Yin, 2009). In order to do this informed consent must be obtained from the participants, protecting the participants in the study from harm as well as taking special precautions to protect vulnerable groups (Ezzy, 2010; Hammersley & Traianou, 2012; Kvale & Brinkman, 2009; Yin, 2009).

In the current study, participants were recruited through a letter of invitation (Appendix C). Once the participant agreed to take part in the study, informed consent

was obtained from the participant by alerting them to the nature of the case study and soliciting their volunteerism in participating in the study (Appendix F) (Ezzy, 2010; Hammersley & Traianou, 2012; Kvale & Brinkman, 2009; Yin, 2009). Participants were provided with the letter of invitation (Appendix C) prior to the interview. At the time of the interview with the researcher, the participants were greeted and asked to read and sign the consent form (Appendix F). At this time they were provided with the opportunity to ask any questions they may have before starting the interview process. They were also provided with a copy of the consent form.

Confidentiality. It is essential to protect the privacy and confidentiality of those who choose to participate, so that as a result of their participation they will not be put in an undesirable position (Ezzy, 2010; Hammersley & Traianou, 2012; Kvale & Brinkman, 2009; Yin, 2009). In order to do this, the only identifier that was collected was the participant's job title. The confidentiality of participants selected was ensured as outlined above through the process of asking for 60 names and the researcher only contacting 11 of these individuals. The job title identifier was only linked to the data, as it was important to assess whether there were differences between perceptions of use of the PDoV depending on the different job roles in the organization. The information was separated in storage with only the researchers knowing which interview transcript was linked to which job title. However, it is important to note that there was multiple participants in several job roles therefore, ensuring anonymity of the data. Any information discussed in the interview containing identifying information was deleted from the audio file and transcripts pseudonyms were used that allowed for the context of the data to be understood. The only people who have access to the data are the

researchers. Furthermore, interviews were conducted at the participant's location and time of choice. All information was de-identified during any communications of the results. Any quotes that were used from the interviews were only attributed to a job title and not to individual participants. The data is presented in aggregate forms outlining common themes and categories that were apparent across the participants. Finally, the interview audio files are stored on a password protected research computer. Any hard copies of the data are stored in a secure filing cabinet in the investigator's research office. The audio files will be deleted at the completion of the study. Transcripts are archived on a data storage device and will be stored in a locked cabinet for seven years.

Chapter 4 – Results

The following results section is presented in two separate yet complimentary sections. First, the case description is presented. This provides an overview of the case where the study took place, in order to provide context. In the second section, the core themes and sub-themes are described, accompanied by associated quotes to explain the results.

Case Description – The Context

The Ontario Government developed the ECFAA in 2010, with the mandatory requirement that each Ontario hospital develop a PDoV through a community consultation process. Prior to this mandate the leaders of the hospital conducted a consultation process with 2,000 members of their community in order to develop their 2015 Strategic Plan. As the hospital had already completed their community engagement process and developed a strategic plan, they decided not to create another document as a result of the ECFAA mandate (i.e., PDoV). They did not want the PDoV to overlap with the strategy that was already created. For this reason, they used their five guiding principles (respect, engagement, accountability, transparency, and value for money) from the strategy to include in their PDoV that can be found on their website.

As stated in the methods section of this study, participants were asked about their knowledge of the PDoV, as this would allow for an in-depth understanding of the content of the document and its development. Responses to this question indicated that employees and patient experience advisors were either unfamiliar or slightly familiar with the document; however when presented with the PDoV document, almost all employees and patient experience advisors identified the values as the guiding principles that were

located within the strategy, with which they were familiar. The hospital's administration decided to call the values in the PDoV "guiding principles", as the hospital's leadership team created tangible behaviours and actions that could be linked to each value. For this reason, in the following results section, the PDoV will be referred to as guiding principles, in order to remain consistent with the language familiar to employees and patient experience advisors.

The guiding principles reflect the term PFCC. When employees and patient experience advisors were asked to define the guiding principles, they used the term PFCC to explain. PFCC within this hospital organization was defined as including patients and families in all aspects of hospital life. For this reason, the term guiding principles will be used interchangeably with PFCC throughout the results and discussion section, to remain consistent with the language used by employees and patient experience advisors throughout the organization.

Employees and patient experience advisors in the current study are dedicated to helping others achieve their vision of PFCC. Individuals within the organization provide tours and workshops to others interested in PFCC, to encourage and help improve the patient experience within other Ontario hospitals. For instance, employees in human resources share their presentations and interview guides with external organizations to help them recruit and hire individuals who share PFCC values. Further, patient experience advisors provide advice and feedback to other organizations that are on the PFCC journey and who are trying to incorporate patient and families on committees throughout the hospital.

Thematic Analysis

Five key themes emerged through the qualitative interviews, highlighting one hospital's success at incorporating PFCC policies and practices within the acute care environment. Table 4 summarizes the themes and sub-themes of the current study. Below, each of the themes presented in the table are described in detail and supported with quotes in order to provide an in-depth understanding of the theme. For additional quotes in each theme, see Appendix I.

Table 4
Summary of Major Findings

Main Theme	Sub-Themes	Summary of the Theme
Setting the Stage	1) Respect 2) Engagement 3) Accountability 4) Transparency 5) Value for Money	This theme highlights the importance of a strategic direction within a hospital organization. Employees demonstrate unity as they have a strong identification with the guiding principles, leading to positive behaviours being exhibited within the hospital environment.
Inspiring Change	1) Patient Experience Advisors 2) Defining Patient and Family Centred Care 3) Motivating People	This theme demonstrates the importance of inspiration and motivation among employees. It explains how the strategic directions set through the consultation process were successful factors in motivating PFCC among the employees. The participants' motivation was fostered through patient experience advisor narratives, which helped develop PFCC behaviours among employees.
Organizational Structures	1) Empower Patient Experience Advisors 2) Foster a Supportive Environment 3) Continuous Improvement	This theme illustrates the characteristics of the hospital that fostered a supportive environment. The hospital empowered patient experience advisors by involving them not only on committees, but also at the bedside. The leadership team ensured that employees felt supported in their PFCC initiatives and encouraged PFCC behaviours by incorporating them into employee performance reviews. Finally continuous improvement through on-going auditing and education was implemented.
Organizational and	1) Lack of Time and Resources	This theme describes the barriers to PFCC within the acute care environment. Employees

Environmental Barriers	2) A System Perspective 3) Recognizing Staff Expertise 4) Environmental Challenges	often lack time and resources, leading to compassion fatigue and burnout, thus hindering PFCC. The physicians/directors in this study explained PFCC from a system perspective, indicating that PFCC was not about individual care. Employees of the hospital often times felt as though they were not being heard, as patients and families were the main priority. Finally, policies and benchmarks created by decision-makers present difficulties in truly attaining PFCC.
Reflection and Improvement	1) Culture Shift 2) Moving Forward	This theme describes elements of the culture shift within the organization. Employees and patient experience advisors now recognize when policies and practices within the hospital are not patient and family centred. These individuals have committed to PFCC within the organization, leading to more positivity in the care environment and creating a better community profile.

Theme 1: Setting the Stage

The following theme showcases the importance of setting the stage, and providing a patient and family centred direction, with which employees and patient experience advisors can relate. The leadership team in this case study, with the help of the community, developed a strategy that included five guiding principles: (1) respect, (2) engagement, (3) accountability, (4) transparency, and (5) value for money, that are explained as sub-themes within this section.

When examining the 2015 Strategic Plan document, the first strategic direction outlined is to: "transform the patient experience through a relentless focus on quality, safety and service." This is a clear theme that resonated through the interviews and the document analysis. The strategic plan document outlines in order to achieve the strategic direction, they will: (a) engage patients in all aspects of quality, safety and service improvement initiatives, (b) eliminate all preventable harm to patients, and (c) eliminate

all preventable delays in the patient journey. The specific initiatives planned to accomplish this include: (1) establishing a Patient Advisory Council, with patient experience advisor roles, (2) integrating patient experience advisors in key hospital activities, (3) adopting patient-centred communication standards, (4) improving patient satisfaction, (5) improving the patient safety culture, (6) reducing hospital-acquired infections, (7) managing patient flow, (8) reducing wait times, (9) implementing a medicine reconciliation process, and (10) implementing a new corporate quality and safety plan. Employees and patient experience advisors explained that these elements "bring the focus back to the patients and families, so that we're moving away from being organization-centric to being more patient and family-centric", and we understand that "this isn't about us, it is about the patients and their families." Employees indicated that the strategy has provided an unwavering direction that is focused on PFCC, outlining that this is a priority and not an option.

Within the strategy lie the five guiding principles: (1) respect, (2) engagement, (3) accountability, (4) transparency, and (5) value for money. The guiding principles provide employees and patient experience advisors with key values and tangible behaviours that are expected of them in the care environment. Understanding how employees and patient experience advisors operationalized each guiding principle in the care environment was critical to answering the research question of the current study, and therefore is explained in-depth in the following sub-themes.

Sub-Theme 1: Respect. As part of the guiding principles, respect is defined as, "we treat every person we encounter the same way we like to be treated ourselves." Although this definition indicates to treat every person the way that you would want to be

treated, many employees disagreed with this. They indicated that their focus was on treating patients the way that the specific individual wanted to be treated, not how they, the employee, would want to be treated. For example a program manager describes:

> It's not the way that you wish to be treated, or someone else. We're individuals. We're very different, so respect is a common language that you share and it's just having an underlying or an understanding of one another.

This description of respect demonstrates that although employees and patient experience advisors use various definitions of respect, it is still understood as a common value within the hospital setting. Other employees indicated that you "should always treat someone well, even if they treated you unwell." Patient experience advisors believed that not only patients and family deserved respect, but employees within the hospital deserved respect as well, and needed to be able to respect each other.

To practice respect five behavioural standards were developed by the Patient and Family Advisory Council for employees, which include: (1) whiteboards, which serve as a communication tool for patients and families, (2) name tags, which are reassuring for patients and families and contribute to a safe environment, (3) communication, which expects that every person who enters a patient's room will introduce themselves, describe their role, and what they are there to do, (4) hourly rounding, which increases safety and reduces patient anxiety and the use of call bells, and (5) patient feedback forums, which provide an opportunity for staff and physicians to hear directly from the patient and family what factors influenced their hospital experience. A program manager describes the employee identification badge:

> One of them is around making sure that staff are wearing their ID badges, and they need to be in the upper portion of the chest, and nothing covered over with tape or other little stickers, or things of that nature, so they can very clearly see what my name is and what my position is. All employees in the hospital are expected to do that.

Name badges within the care setting are important as they ensure patients and families know the name and the position of the employee. This contributes to continuity in the care experience. Employees in multiple roles and patient experience advisors all described at least one of these standards when asked about practices that promote respect. This demonstrates consistency with the definition and behavioural standards.

Sub-Theme 2: Engagement. Within the guiding principles, engagement is defined as, "we encourage and support the involvement of our internal and external communities in all aspects of [hospital] life." Employees and patient experience advisors identified engagement as the involvement of various groups in the strategy development and care planning processes. An allied health professional explained that engagement included not only patients and families, but also employees within the hospital. Throughout the interviews, employees indicated that engagement "is not a one-time deal", and that it needs to be an interaction between at least two people, involving the patients and their families, specifically in decision-making related to their care. Fostering engagement can sometimes be a difficult process; however enabling trust in the health care environment has been seen as key to engaging patients and families. For instance, a registered nurse describes how patient and family engagement can be achieved:

> I'm going to come in, hopefully as someone that the patient can trust, they can speak to easily. I'm going to make it as comfortable as possible, our meeting. I want to engage them. If I'm going to be looking for the information and the things that I need to make their stay as best possible, I need to make sure that I'm the kind of person that they're going to want to trust, want to confide in.

As demonstrated by this description, engagement is seen as more of a relationship and a partnership. Patient experience advisors explained this as "nothing about me, without me." This statement is critical in the health care environment, as employees and patient experience advisors should not be imposing their expectations on patients and families, which was previously mentioned in the respect sub-theme.

Sub-Theme 3: Accountability. Accountability is described within the guiding principles as, "we are responsible for the decisions we make and the results we achieve as individuals and teams." All employees and patient experience advisors throughout the organization agreed that accountability was divided into three sections: (a) accountability to the community, (b) accountability to the patients and their families within the hospital, and (c) personal and professional accountability. For example, a patient experience advisor describes accountability:

> I think it's just that the organization should be accountable for the decisions that they make and the policies and procedures they make and that they are accountable to their stakeholders, essentially, but ultimately to patients and their families in the communities.

Although employees and patient experience advisors were able to define accountability, as demonstrated by the above description, they also found it difficult to identify examples of accountability within the organization. Employees were hesitant to be accountable in fear of consequences. This suggests that accountability is an area for improvement within this hospital case.

Sub-Theme 4: Transparency. As part of the guiding principles, transparency is defined as, "while respecting the privacy of our patients and staff, we communicate clearly, openly and honestly about everything we do. We do not hide from difficult

conversations, and we share both our success and our opportunities for improvement." This definition is consistent among employees and patient experience advisors throughout the organization; however similarly to accountability, transparency was found difficult to achieve in practice. Participants indicated that this is improving everyday and by having patients and families participate in decision-making, transparency and accountability have improved from previous years. For instance, a director further explains:

> We heard that sort of talk when we first started doing this as well, the concern about "Can we have an open conversation when patients and families are present?" I think we can, but it goes back to that respect piece. Having somebody there who might be listening with a critical ear actually makes people talk in a more respectful way.

As seen above, including patients and families in decision-making has improved transparency within the organization and has also fostered respect.

Sub-Theme 5: Value for Money. In the guiding principles, value for money is defined as, "we are responsible stewards of resources, striving always to achieve the greatest results for the money entrusted to us over both the short and the long term." Participants described being responsible for the money that is being spent and that the leaders of the hospital are accountable to the community, as the community is the funder of health care. Employees and patient experience advisors also spoke about the importance of being LEAN in health care by describing, "although the hospital is a health care setting, it is also a business and needs to be run like a business, which is a challenge in the current state of health care." An interesting concept that emerged from a patient experience advisor was the idea that if the focus were on improving quality, the value for money would be apparent:

> There needs to be, and I really believe that involving patients and families, and using the focus of improved patient quality and safety as everybody's goal. If you take everybody and you say, that's the goal, no matter what your interests are, whether you're a patient, family, physician, whatever, politician, the goal is, we're going to improve patient safety and quality. In the end, if that's the goal, you will save money. You will have value for your money, because you're providing good, quality care.

Through the following patient experience advisor account, it is clear that the focus should be improving patient safety and quality. By pursuing this vision, money will be saved and in turn value for money will be achieved. There will be good quality care for every dollar that is spent.

Theme 1 Summary. In summary, the development of the strategy was the first step that solidified PFCC in the hospital environment. When employees and patient experience advisors were asked to define and provide examples of the guiding principles, all participants were able to relate to the guiding principles, and provide relevant examples of each within their own discipline. Although some guiding principles were identified as needing improvement, the strong identification of employees and patient experience advisors with the guiding principles allowed the leaders of the organization to set a firm PFCC direction. As the direction was set, the next theme describes how employees were motivated to practice PFCC in the acute care environment.

Theme 2: Inspiring Change

As previously outlined, the strategic plan provided the employees and patient experience advisors with an unwavering PFCC direction. In order to motivate and inspire PFCC among employees, the patient experience advisor role was created. The involvement of patient experience advisors allowed employees to hear patient narratives, cultivating a sense of identity among staff and encouraging PFCC behaviours. The

following theme describes three sub-themes: (1) patient experience advisors, (2) defining patient and family centred care, and (3) motivating the people.

Sub-Theme 1: Patient Experience Advisors. The Patient Experience Advisor Handbook defines a patient experience advisor as, "a person who has had a recent experience (generally in the last three years) of being a patient or the family member of a patient and is partnering with staff and physicians to provide direct input into policies, programs, and practices which affect patient care and services." Patient experience advisors are generally on the Patient and Family Advisory Council, and participate on various committees throughout the hospital to ensure that the patient's voice is being heard. The patient experience advisor role was created in 2010, and has drastically evolved since then. Patient experience advisors participate in the conversation and are involved in all aspects of the hospital. A patient experience advisor explains:

> Watching the evolution of this has been really interesting. What I've seen is that, the groups that have had experience working with patient advisors, and who have leadership that have been trained to work with patient advisors, there's more of them, and they're open and very solicitous. Very much include you in the conversation. Very much would not consider doing a project without you being there, as opposed to when we first got started, and it was king of like, okay we need a patient advisor, but we're not sure why.

The patient experience advisors describe how employees throughout the hospital include them in the conversation and consult them on various projects, leading to a sustained partnership.

When employees were asked about patient experience advisors, they all expressed that they had at least one experience working with them on an initiative within the hospital. A clinical manager described the patient experience advisors as, "being the most powerful committee in the hospital due to the different perspectives that they bring to the

health care setting." Employees also expressed that having patients and families on councils throughout the hospital is a benefit for the hospital. It allows patients and families to have a better understanding of the struggles that the hospital faces in the health care environment daily. An occupational therapist explains:

> I think also it really helps with them have a better understanding of the challenges that health care professionals face. There are challenges. There are resource challenges, and just the tough dynamics of the complexity of the issues that we deal with. There's not just a quick answer all the time, it's a process that I think having them at the table allows them to be more aware.

By including patients and families in all aspects of the hospital, as patient experience advisors, patients and families participate on projects, and have a better understanding of hospital processes such as successes and barriers. Through engagement of patients and families, a nurse manager indicates that the hospital is, "reaching out to have a connection with the community." This helps create more community awareness.

Sub-Theme 2: Defining Patient and Family Centred Care. When asked what PFCC meant, the nurse practitioner and the nurses explained that PFCC meant "looking at the person as a whole", "in a holistic way", and ensuring that trust was in place in the care environment. The porter and maintenance worker believed that patients created the hospital, and "we should be going the extra mile" to help the patient and their family during this difficult time. Additionally, a number of employees and patient experience advisors believed that PFCC was "working together with patients and families" to achieve optimal health outcomes. No decision throughout the organization should be made without patient or family involvement. A patient experience advisor explains PFCC:

> I think it means that we work together. We're a team, the advisors, the patient, the doctor, the caregivers, the nurses, that we work as a team, and we work together, and we corroborate together, and we produce things together, and together we are going to make this the best hospital that we can.

In this example, the patient experience advisor emphasizes togetherness by working, collaborating, and producing together to improve the hospital. This explanation of PFCC is also consistent with the engagement definitions provided in theme 1 (sub-theme 2). This further outlines the link between guiding principles and the underlying concepts of PFCC.

An example of working together was the implementation of resting stations throughout the hospital. Accessibility benches were added to the hospital in various hallway locations, in order to make the hospital more accessible to elderly individuals or those with disabilities. This was a request made by patients and families, and they worked together with hospital employees to resource and place these benches in appropriate locations.

Sub-Theme 3: Motivating the People. When interviewing the employees and patient experience advisors, it was clear that they understood their role within the hospital. The participants were able to articulate their specific job roles and the importance of their PFCC role. A maintenance worker indicates, "here my job is to try to make somebody feel that they are important to the hospital." All employees wanted to help patients and let them know that their voice mattered. Patient experience advisors on the other hand explained why PFCC mattered to them.

Employees understood and explained that they or their family member might one day be sick and require acute care services at the hospital. For this reason, it was

important for them to "get it right", and ensure that when they or their family members required those services, the care would be positive and of high quality. A program manager explains:

> We have to get it right, because this is where we're all coming when we're sick in this community. Let's face it. This is where we're coming, our families are coming, so if we don't get this right, it's going to directly impact you somewhere down the road for sure.

Other employees within the organization also echoed this statement. The employees reflected on the situation and put themselves in the patient and family position. They wanted to ensure that they were providing the best care possible to patients and families.

The patient experience advisors expressed that they wanted to make the hospital better for the next patient and family, so that what happened to them or their family member did not happen to another patient ever again. A patient experience advisor describes her personal experience:

> I think that's why most people volunteer, because eventually, we're all going to be in this hospital for something, and whether it's me or the next person down the line, or my husband, I want it to be the best care they can have. It's not always going to have the most positive outcome. I can tell you that. I've been in this hospital for a long time, and it's not always positive, it's not always rosy, and things do go wrong, and things go badly, and surgeries get cancelled, and things happen, but we have to learn from it. If we don't learn from it and grow, then what's the point?

As demonstrated in the above description, for the patient experience advisors it is about helping the next patient or family that comes to the hospital. The patient experience advisors outlined that it's not always about the best possible outcomes, but learning from those mistakes and growing to make the hospital better.

Both employees and patient experience advisors expressed willingness to make a difference in the lives of patients, families and staff. In turn, this willingness to make a

difference made them feel good about themselves. They expressed this as “people have an interest in care”, “they have an interest in quality care”, and “they have a real interest in making a difference in the lives of individuals.” The majority of health care providers go into health care as they have this internal desire and drive to care for others, and do not intend to make the lives of patients and families difficult. Employees felt valued in their roles and therefore wanted to give back to patients, families, communities, and each other.

Theme 2 Summary. In order to carry out the strategic direction, employees within the organization needed to be motivated to provide PFCC. Motivation was fostered through the creation of patient experience advisors, who became a core group within the hospital that helped support PFCC. This ultimately allowed employees and patient experience advisors to understand what it meant to be patient and family centred. It defined their role within the care environment and uncovered their desire to help others and make a change. In addition to identifying with the guiding principles and being inspired to create patient and family centred change, it was essential that organizational structures be created to ensure that direction and motivation were indeed supported and could be sustained in the care environment.

Theme 3: Organizational Structures

Modifying the situation ensures that employees and patient experience advisors always make the right choice. Creating a supportive environment is critical to the successful implementation of any initiative. In order for the initiative to be successful, the organization must: (a) empower patient experience advisors, (b) develop an environment where leadership encourages the initiative, and ensures that staff are supported in the

implementation of the initiative in practice, and (c) engage in continuous improvement and participate in education and training practices to further develop knowledge and enhance skills.

Sub-Theme 1: Empower Patient Experience Advisors. In order for the hospital's mission to be successful, empowering patient experience advisors was necessary. Patients and families are included in decisions about their care, as well as in every policy or practice decision within the hospital.

At this leading Ontario hospital, the term PFCC is used among all staff. The inclusion of the family into the care setting is very important. The employees and patient experience advisors expressed that families, "know the patient better than all of us", and should help provide the patient's history and make decisions. Examples of involving the family include: (a) the elimination of visiting hours, where families can stay in the room overnight if needed, and (b) access to the recovery room after surgery when the patient is stable.

A few years after introducing patient experience advisors, a new hiring process was instituted, where multiple employees and patient experience advisors interview candidates. There has been tremendous success with this new hiring process as the PFCC lead indicated, "You stop people at the front gate who don't get it." With this new process, the leadership team has found that the values of newly hired employees now better align with the guiding principles of the organization.

Decision-making in the hospital is made using the Patient and Family Advisory Council, where patients and families make all decisions. This also includes the development and revision of all documents that are released in the hospital. Of note,

decisions that are made at the clinical level and on the frontlines are done from the patient perspective, and involve the patient and family in the process. However, at times it is necessary for patient and family training in the decision-making process. This is highlighted by a nurse practitioner:

> That is easy because many of the decisions that you have to make have to involve the patients. They have to agree to it. If they're not going to agree to the plan, they're not going to do it. There's usually something missing or information that they don't know or there's some gap or they want to do it in a different way.

This description outlines that when patients and families are not involved in the decision-making process, they are likely not going to agree to the plan that was developed for them. By truly engaging patients and families in the care environment, this has allowed for the patient voice to be heard and has also allowed employees to begin thinking from a new perspective: the patient and family perspective.

Sub-Theme 2: Foster a Supportive Environment. Employees and patient experience advisors indicated that they felt supported in their PFCC initiatives because the leadership team encouraged the initiatives, were clear about the direction of the organization, and modeled the practices at every step of the way. An allied health professional describes the impact this has had:

> A lot of it comes from our leadership. They're also just an amazing group of people as leaders, who have supported us in doing it, and remind us about it, and show that they're doing it constantly. It becomes part of everything, having the patient advisors as part of our teams.

This description illustrates the impact that the leadership team has had in creating a support system. As employees in leadership positions were continuously reminding their employees and modeling the way, they created a supportive environment within the hospital.

A number of individuals outlined the importance of communication. They expressed that they received feedback from the leadership team, and were able to provide them with updates on their progress to showcase their improvements or barriers to success. This helped to foster a supportive environment. Further, hospital administrators incorporated the guiding principles into employees' performance reviews, to ensure that the desired behaviours were being achieved. A program manager indicates that this provides her with "an opportunity to weave in the patient and family."

An allied health professional and a nurse practitioner also spoke about support in others ways. The allied health professional explained that support also meant "supporting the patients and that there were times where there was no need for providers to be interventionists, but rather support staff to the patient and family." The nurse practitioner explained that "feeling supported actually came from the patients and families." When patients and families supported the staff in the initiatives, they in turn felt supported providing PFCC.

Sub-Theme 3: Continuous Improvement. In order to foster a supportive environment, the leadership team was continuously improving and stretching the status quo. Further, they ensured that employees were consistently up to date on best practices, and felt comfortable using their acquired knowledge and skills in everyday practice.

Employees implemented a mechanism for continuous auditing and feedback, where the results are presented to staff and patient experience advisors on an on-going basis. An example of a practice that is monitored is hand hygiene. Results of hand hygiene audits are posted on a monthly basis in the surgery ward, as described by a program manager.

Throughout the interviews, employees and patient experience advisors described an important piece of education and training. During this training, they were either participants in the training that was given by their peers or they were actually the ones instructing their peers during the training, utilizing a peer-to-peer model.

The employees and patient experience advisors received formal training on PFCC through the H.E.A.R.T. program. The H.E.A.R.T. program (Hear the story, Empathize, Apologize, Respond to the problem, Thank the person) was created by the Cleveland Clinic, modified for use in this hospital and implemented throughout the organization. It's a healthcare-focused model that provides employees, volunteers, and patient experience advisors with the practical knowledge to address patients concerns. A nurse practitioner explains:

> It's a very good philosophy of training on responding appropriately to people, apologizing when we've not done it the best way that we could, how do we fix it, and move forward. It's a focus of approach and I think it was a really good focus of approach, this H.E.A.R.T. training. Telephone manners, how to respond to people over the phone with empathy and understanding.

The H.E.A.R.T. training provides employees and patient experience advisors with the opportunity to understand PFCC and associated behaviours, to practice them within the care environment.

Theme 3 Summary. Various PFCC support structures are key in the health care environment, as they ensure that positive behaviours are being reinforced. In this case, empowering patient experience advisors, supporting employees through feedback and performance reviews, and fostering a culture of continuous improvement created a supportive environment within the hospital. The following theme outlines barriers to PFCC within the care environment.

Theme 4: Organizational and Environmental Barriers

As explained throughout the interviews, there are still pockets of the organization that struggle with change more than others and that are not patient and family-focused. The four main barriers to change that were described include: (a) lack of time and resources, (b) a system perspective, (c) failure to recognize staff expertise, and (d) environmental challenges. Despite the struggles, employees and patient experience advisors are committed to sustaining PFCC in practice.

Sub-Theme 1: Lack of Time and Resources. One of the main barriers to PFCC within the acute care environment is a lack of time and resources. Employees indicated that there were simply too many patients and not enough employees to ensure that all patient and family needs were met. This was leading to employee burnout and compassion fatigue among staff. An occupational therapist explains:

> It's that compassion fatigue of dealing with things that you can't do quickly, and you don't have the resources to do. I mean there's more patients here, so everybody feels that increase in occupancy. More and more, then, you're having to prioritize. You're seeing, from a rehab perspective, either people are discharged without being seen because you didn't get to them, or they're not getting the same frequency of treatment that they normally would get if we were back at our more typical volumes.

A lack of time and resources within the hospital setting led to an increase in burnout and compassion fatigue among employees. When employees are not able to properly take care of themselves, they found it difficult to take care of others, thus acting as a barrier to PFCC.

Sub-Theme 2: A System Perspective. An interesting theme that emerged from the physician and director perspective was the idea that "PFCC did not mean individual care", nor did it simply mean "treating the individual in front of you" or "catering to their

needs." It meant the right care, at the right time, and a balance between all patients. Physicians describe PFCC as being cognizant of the other people in the environment, including the patient in the next bed, in an effort to protect privacy and ensure confidentiality. They explained that PFCC was only possible when one patient's wants and needs did not interfere with another's. The physician explains this concept in depth:

> I think the trust in that is patient-centred care is not just the patient in front of you. It's the patient that's in your waiting room; it's the patient that downstairs in emerge that you see upstairs; it's the patient that can't get transferred in. Your patients are not just the ones in front of you. It's the ones you can't see. It's the next one to come in. That's what patient care should be all about. That's what patient-centred care should be all about.

This description highlights an important aspect of PFCC that was not previously considered. This view of PFCC conflicts with previous definitions and perspectives. PFCC describes the importance of the individual patient and family care; however does not account for others in the environment. This sub-theme demonstrates the importance of looking at PFCC not only from the bedside perspective but also at a system level.

Sub-Theme 3: Recognizing Staff Expertise. It was noted that employees within the organization often felt as though the leadership team did not recognize their expertise. By focusing on patients and families, and being such a PFCC hospital, employees felt sometimes unheard and unsure where they fit within the organization. Employees felt that they should be included in the decision-making process, when the decision had an impact on their daily tasks or role within the organization. A registered nurse explains this issue further:

> Sometimes, it's a bit of a source of frustration because some initiatives that co-workers have tried to move forward, which I think are valid and certainly beneficial to our patients, the patient advisory committee has looked at it, and for whatever reason, have decided to put it on the back burner. I think that's a bit frustrating. I get the input that they bring, and it's important because they have a whole different set of eyes, and a voice that we sometimes get muffled in our day-to-day work. Sometimes, I know, it can be a bit frustrating, but they're coming from a different perspective, so I do respect that as well. As with anything, sometimes it's good. Sometimes not so good.

As this hospital is extremely patient and family focused, patients and families are included in all decision-making conversations, whereas employees are sometimes excluded from the discussion. This made them feel as though their expertise was not recognized in certain situations. In order to overcome this barrier, it is important to include both employees and patient experience advisors in the decision-making process.

Sub-Theme 4: Environmental Challenges. Employees outlined environmental challenges in the care environment that impacted their ability to engage in PFCC. Of the many environmental challenges that exist in health care, alternate level of care (ALC) guidelines were described as one of the biggest challenges. ALC guidelines present a distinct challenge within the care environment, in terms of providing PFCC. Benchmarks in the acute care environment, in terms of length of stay and ALC patient designation, pose great challenges and prove to be barriers to PFCC. The government has outlined that it is cheaper to provide care to these patients. Where there is an increase in ALC patients, there is a decrease in staff to patient ratios, as these patients do not have medical problems that require acute treatment. An occupational therapist explains:

> You have the pressures of an acute care environment, where the goal of care, say might be length of stay if three days for this patient, but the patient is saying, 'I'm not ready to go. I can't do this.' You're feeling conflicted that the patient is saying they're not ready, but maybe in actual fact you've assessed them, they are ready, and you know organizationally and targets are saying this patient should be gone in three days. Those are things that, even though we've moved in that direction, those are still challenges today. Those have always been there, because, I think of our environment.

As described by the occupational therapist, ALC guidelines developed by the provincial decision-makers have created barriers to PFCC. This is in part due to the competing interests of all stakeholders (i.e., patients, caregivers, and benchmarks set by the provincial decision-makers).

Theme 4 Summary. This theme explains PFCC challenges that exist in the care environment. Although employees and patient experience advisors described a number of challenges, they also described the PFCC process as a journey, where they will strive to continuously improve. Employees and patient experience advisors described next steps for the hospital: frontline engagement and accountability, improving the experience for all patients, improving communication within the hospital and throughout the community, addressing staff compassion fatigue, continuing to increase the number of patient experience advisors within the hospital, and continuing to be leaders in this area. Further, the employees and patient experience advisors stressed the importance of finding tangible ways to measure their successes.

Theme 5: Reflection and Improvement

In order to understand the current state of the organization, it is important to look back and understand the direction forward. The following theme describes the culture shift, the commitment of employees and patient experience advisors to PFCC, and next

steps for the organization.

Sub-Theme 1: Culture Shift. Over the last five years, the organization has gone through a transformative change: a culture shift. Employees and patient experience advisors describe the organization as "no longer top-down driven", where PFCC is ingrained in the practices of the hospital on a broader level, and can be seen on numerous units. Individuals are now stopping to think about the patient and their families. It was made clear by multiple participants that they really noticed when practices and policies are not patient and family centred. In 2009/10, this hospital was struggling not only financially, but also with patient satisfaction and quality of care scores. Upon examination of the patient satisfaction scores, this leading Ontario hospital has sustained a 95% patient satisfaction score with overall care during the last five years (2010-2015).

As employees leave, the leaders of organization are replacing these employees with individuals who demonstrate PFCC values. Employees and patient experience advisors indicated that employees within the hospital really want to make a difference, and are committed to partnering and working together to achieve the best health services possible. Ensuring that patients and families are incorporated into every part of the hospital, and ensuring that they are on committees throughout the organization, is key to the culture change. This has allowed for more energy and positivity from employees and patient experience advisors. Individuals within the community are happier, there are fewer complaints, and everyone is excited about the changes. This is leading to a better community profile. A patient experience advisor explains:

> I think one of the things that really strikes me now, is that, we really notice when things aren't patient centred, whereas before, things were what they were. Now, what happens is people recognize when it's not patient centred. Our levels, our targets, I think gradually get higher, so your expectations get higher, of the environment.

This description demonstrates how individuals throughout the organization now notice when things are not patient and family centred, whereas five years ago individuals did not know what PFCC truly meant. As PFCC continues to evolve throughout the organization, the expectations continually increase.

Sub-Theme 2: Moving Forward. Employees and patient experience advisors described their recent successes as, "only the beginning of the journey", and "something that you can never complete". Employees and patient experience advisors want to ensure that the momentum keeps going, and that they do not get stuck in their old habits. Moving forward, all were committed to making sure the system was truly patient and family centred. A director further explains:

> I think it's on multiple levels that it will continue to evolve, and I don't think we've seen the end of this; I think this is the beginning of the journey, and I don't think we know what the extent of it could be yet.

As demonstrated by this director, individuals within the hospital will continue on the PFCC journey to ensure that the patient and family experience within the hospital can be as positive as possible.

Theme 5 Summary. A culture shift has occurred within the organization. Employees and patient experience advisors are committed to sustaining PFCC and continuing to be leaders in this area. Although the practices and policies at the hospital over the last five years have led to a culture change, there are a number of challenges and barriers that need to be addressed in order to continue partnering with patients and

families.

Chapter 5 – Discussion

The purpose of this research project was to explore how a leading Ontario hospital in PCC operationalized their PDoV statement. Of specific note in this study, the intent was to examine how the PDoV was operationalized in policy and in practice. The leaders within this organization reformed this mandate based on their own organizational lens and language of "guiding principles." This was followed by the development of core strategies (i.e., patient experience advisors), a focus on inspiring the workforce, and providing a working environment that was consistent with the direction, all of which led to change and commitment to the PDoV (i.e., guiding principles). As an exemplar, this leading Ontario hospital case lends itself to providing a frame of reference and core steps and strategies that could be considered by other acute health care organizations.

In general, this study is consistent with previous literature on change management, organizational change, as well as the notion of gradual and incremental cultural shifts towards PFCC. The results of this study support PFCC in practice, when the proper structures (i.e., guiding principles, patient experience advisors, motivation, support, and continuous improvement) are in place, and offers guidance on PFCC change management strategies for the acute care setting. Although challenges around change management in the health care setting are not new, the current study provides insight on PFCC barriers within the acute care environment. A key example is the gap between various sectors (i.e., government, policy- and decision-makers, acute care organizations, and individuals at the frontline) in relation to what this means to implement PFCC in the practice setting. The current study provides insight on the importance of bridging the gap between theory, practice, and policy in order to address common barriers to change and

improvement in the health care environment. It is essential that the follow-up and evaluation of policies occur on an ongoing basis to ensure all stakeholders understand the implications and challenges of the suggested mandate.

In this case, it was evident that the PDoV was not a term commonly understood by employees and patient experience advisors; yet they were familiar with the guiding principles. They attributed the guiding principles to the notion of PFCC, as they believe that care should be centred around the family as well. Therefore, PFCC will be referred to in the following discussion interchangeably with PCC and the guiding principles to be consistent with the language used by the organization. Figure 5 provides an overview of the core steps and strategies that influenced the implementation of PFCC.

Figure 5 provides five steps and 16 core strategies to achieve PFCC in the acute care environment. The first step is setting the stage. To effectively set the stage, the engagement of the community through a consultation process was necessary to ensure they were involved in developing the strategic directions and guiding principles of the organization. Once the guiding principles are developed, it is important to associate desired behaviours with each principle to ensure employees understand what is expected of them. At this time, examining organizational and environmental barriers to change and mitigating risks will help ensure that the strategic direction can be achieved.

In the second step, inspiring change occurs when patient experience advisors are involved in the decision-making processes within the hospital. This allows employees and patient experience advisors to define and truly understand PFCC. The patient narratives provided by the patient experience advisors motivate employees to change their behaviours and practice PFCC.

Figure 5. Core Steps and Strategies for Patient and Family Centred Care in the Acute Care Setting.

The third step is developing and implementing organizational structures that enable PFCC behaviours in practice. Strategies that can be used to embed PFCC into the organizational structures include: empowering patient experience advisors through decision-making, support by the leadership team within the organization, and continuous improvement (i.e., auditing, quality improvement initiatives, and education).

Identifying organizational and environmental barriers is the fourth step. In this step it is important to identify the challenges to PFCC. In this case, challenges identified were lack of time and resources, PFCC system thinking, recognizing staff expertise, and

environmental (policy) challenges. Although this is the fourth step of the process in this hospital's case, this step in the process is informative for other organizations and should be examined in the beginning steps of the PFCC process. It is important to forecast foreseeable barriers prior to or during the first step in order to be more successful in PFCC change.

The fifth and final step is reflection and improvement. During this step it is important to evaluate the change in organizational culture, evaluate employee commitment to the vision and the guiding principles, and determine future initiatives to ensure that the PFCC philosophy is maintained. In this case, the hospital's 2015 Strategy is coming to an end, and they are reflecting on successes and failures in order to develop a new strategy in the upcoming year.

These steps and associated strategies are in part consistent with the change management frameworks offered by Lewin (1952), Kotter (1996) and Heath and Heath (2010). Lewin (1952) describes a three-step model of change: (a) unfreezing, (b) change and (c) refreezing. In the unfreezing stage, there is a perceived need for change, usually in response to a negative event (Lewin, 1952). The unfreezing stage is consistent with the first step (setting the stage) in the current process, where a strategic direction is created to model the new way forward. In the change stage, this is where the change occurs (Lewin, 1952). In the current process, change occurs through inspiring change and organizational structures. Finally the refreezing stage is defined as reducing uncertainty that was produced in the change and redefining the roles and functions within the new system (Lewin, 1952). In the current process, refreezing occurs during the organizational and environmental barrier and reflection and improvement steps.

Kotter (1996) presents an eight-step model for change management: (1) create a sense of urgency, (2) build guiding coalitions, (3) form a strategic vision and initiatives, (4) enlist a volunteer army, (5) enable action by removing barriers, (6) generate short term wins, (7) sustain acceleration, and (8) institute change. The process and core strategies presented in this study align with aspects of Kotter's (1996) eight-step model such as: building guiding coalitions, forming a strategic vision and initiatives (i.e. setting the stage), enlisting a volunteer army (i.e., inspiring change), removing barriers (i.e., organizational and environmental barriers) and institute change (reflection and future improvement).

In the Heath and Heath (2010) book *Switch* the authors highlight the importance of: (a) direction, (b) motivation, and (c) shaping the environment, in order to create sustainable change within organizations. Their three-step model is consistent with the first three steps in the current process (i.e., setting the stage, inspiring change and organizational structures). When setting a direction, Heath and Heath (2010) describe the importance of (a) following the "bright spots" (initiatives that are working) and cloning them, (b) scripting the critical moves, where specific behaviours are created and defined, and (c) pointing to the destination, ensuring that employees understand the direction and why it is important. Heath and Heath (2010) indicate that in order to motivate change, leaders must: (a) find the feeling, as knowing something is not enough and people must feel something, (b) shrinking the change, by breaking down the change into small improvement activities, and (c) growing the people, by fostering a sense of identity. Finally, shaping the environment is outlined as: (a) tweaking the environment, to ensure when the situation changes the behaviours change as well, (b) building habits,

encouraging behaviours so that they become habitual, and (c) rally the herd, where behaviour is contagious and spreads.

Although the findings of the current study are somewhat consistent with the Lewin (1952), Kotter (1996) and Heath & Heath (2010) frameworks, the current steps and strategies are specific to PFCC in the acute care setting, and offer insight on barriers specific to the Ontario hospital context.

Setting the Stage

In this case study, the first step in the process is setting the stage, which includes: the engagement of the community, the development of a strategic plan and guiding principles, and the translation of guiding principles into expected employee behaviours.

The development of the hospital strategic plan was the first step in implementing PFCC within this hospital setting. This was the initial step taken by the hospital administrators to incorporate the guiding principles into the overarching organizational structures, operationalizing the PDoV in policy and practice. A strategic plan is a business tool that identifies the long-term directions for the organization (Schermerhorn & Wright, 2011). Sollenberger (2006) indicates that successful planning needs to begin with ownership of the process and the development should not be top-down driven but, rather a joint organizational effort (Desmidt et al., 2009). For this reason, it is extremely important to have stakeholders at all levels of the organization and within the community participate in planning and implementation of initiatives as they: (a) have a role in achieving the organizational objectives (Sadeghifar, Jafari, Tofighi, Raveghi & Maleki, 2015), (b) it increases communication with stakeholders (Lega, Longo & Rotolo, 2013), and (c) this in turn helps increase the adoption of the strategic plan (Bart & Tabone, 2000;

Desmidt et al., 2009). Further, as indicated by Born and Laupacis (2012) the community is the main funder and user of the health care system, and therefore should be involved when important decisions are being made (Maioni, 2010). This research is supported by the findings of the current project.

The International Association for Public Participation describes the spectrum of public participation: "(1) inform (provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and solutions), (2) consult (to obtain public feedback on analysis, alternatives, or decisions), (3) involve (to work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered, (4) collaborate (to partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution, and (5) empower (to place final decision-making in the hands of the public" (IAP, 2007). The "empower" level of participation is the highest level of impact, whereas inform is the lowest (IAP, 2007). Although many studies identified the importance of empowering the community in strategic planning (Bart & Tabone, 2000; Born & Laupacis, 2012; Desmidt et al., 2009; Maioni, 2010; Sadeghifar et al., 2015), Sadeghifar et al. (2015) reported that only 56% of Iranian hospitals in the study actually engaged their communities in the strategic planning process. The lack of stakeholder involvement in setting the strategic direction does not foster a culture where the strategic plan is achieved together (Lega et al., 2013).

In the current study the hospital's leadership team did empower the community. They identified 2,000 individuals, including patients and families, members of the local and regional communities, partner organizations, and staff and asked them what was

important to them and how they could bring the hospital's vision to life. This process is similar to that of Sollenberger (2006), who described the strategic planning methodology used in their US hospital, where stakeholders from the hospital, medical school and community were consulted. During the hospital's engagement process, going out into the community and understanding the community's values were key to understanding the hospital's direction. This is also consistent with findings from Rubin and Stone (2010) and Born and Laupacis (2012).

Through analysis of the strategic plan, one of the long-term directions set by the hospital was the "engagement of patients in all aspects of quality, safety, and service improvement initiatives." This long-term direction is an example of how the organization embedded PFCC into the organizational structures within the practice environment. In the current study, participants indicated that the development of the strategy was the "push" necessary to begin on the PFCC journey, as this set a clear direction for the organization. This is consistent with findings from previous health care studies, which identified planning and the development of a strategy as a key success factor in organizational change (Begun & Kaissi, 2005; Kash, Spaulding, Johnson, & Gamm, 2014; Spallina, 2004). This allowed the organization to develop a vision with future directions (Begun & Kaissi, 2005), which encouraged goal alignment among employees and patient experience advisors (Kotter & Heskett, 1997), and developed a more homogeneous organizational culture (Spallina, 2004).

Of note, many studies describe the importance of actually carrying out the strategic plan, and developing action plans based on the strategic plan (Begun et al., 2005; Sadeghifar et al., 2015; Sollenberger, 2006). Results from the Sadeghifar and

colleagues (2015) study identified that only a small number of Iranian hospitals within their study (54%) had implemented their strategic plans, and therefore their strategic plan was proving to be ineffective. In the current study, the strategic plan was operationalized, as tangible behaviours were developed and linked to the guiding principles outlined through the strategic planning process. For instance, respect was provided through five expected employee and patient experience advisor behaviours: (1) whiteboards, (2) name tags, (3) communication, (4) hourly rounding, and (5) patient feedback forums.

Through employee and patient experience advisor participation in the strategic planning process, and by attributing expected behaviours to the guiding principles, employees and patient experience advisors were able to understand their purpose within the organization (Bart, 1996b; Bart & Tabone, 1998; Campbell, 1992; Klemm et al., 1991; Ireland & Pitt, 1992), which increased their understanding of the organizational direction (Rubin & Stone, 2010), all of which is consistent with previous literature. Employees and patient experience advisors interviewed during this study were all able to describe and relate to the guiding principles, which is consistent with other studies (Bart, 1996b; Campbell, 1989, 1992; Collins & Porra, 1991; Daniel, 1992; El-Namaki, 1992; Germain & Cooper, 1990; Javidan, 1991; Ireland & Hitt, 1992; Klemm et al., 1991; King & Cleland, 1979; Weiss & Piderit, 1999; Wenstøp & Myrmel, 2006; Wilson, 1992).

Prior to the interviews with employees and patient experience advisors, the interview guide was developed based on Schrøder's (2000) five dimensions for analyzing how employees and patient experience advisors understand the PDoV. A positive result in all five dimensions implies strong identification with the value statement, which leads to a strong organizational culture (Andersen, 2012; Schrøder, 2000). Employees and

patient experience advisors in the current study achieved strong results in comprehension, discrimination, implementation, motivation and position, leading to a positive identification with the value statement, in turn developing a strong PFCC culture. The clearly defined behaviours aligned to the guiding principles allowed employees to be more involved in the organization (Fitzgerald & Desjardins, 2004; Rubin & Stone, 2010), leading to strong shared values (Bart & Tabone, 1998; Fitzgerald & Desjardins, 2004; Kotter & Heskett, 1997; Schrøder, 2000) and ultimately the beginning of a shift in culture (Caroll & Quijada, 2004; Schein, 2010).

This step in the process demonstrates how a leading hospital first operationalized the PDoV in policy and in practice, through the development and implementation of a strategic direction and guiding principles that employees and patient experience advisors understood. When looking at organizational culture, the strategic plan and the guiding principles are the first level of culture; artifacts. As expected behaviours were defined and linked to the guiding principles, employees and patient experience advisors developed shared values and beliefs about PFCC (Schein, 2010). Although this was the first step of the process in changing the PFCC culture of the organization, Sollenberger (2006) and Heath and Heath (2010) indicate that strategic directions will not be achieved unless individuals are inspired to change, and make a difference.

Inspiring Change

The second step of the process is inspiring change, with core strategies such as: patient experience advisors, developing a common PFCC language, and motivating individuals within the organization to participate in the change.

In this case, a Patient and Family Advisory Council and patient experience

advisors were created in 2010, as a strategy to achieve the "engagement of patients in all aspects of quality, safety, and service improvement initiatives" strategic direction found in the 2015 Strategic Plan. The patient experience advisor role was developed to encourage participation by patients and families on various committees throughout the hospital, and ensure that the patient's voice was being heard in decision-making. The involvement of patients and families on Patient and Family Advisory Councils is one of the main strategies used by health care organizations to instil a culture of PFCC within the care environment (Halm, Sabo & Rudiger, 2006). Patient experience advisors provide a better understanding of patient and family needs from a patient and family perspective, which can be integrated into systems and processes to improve services (Halm et al., 2006; Landis, 2007; Luxford, Safran & Delbanco, 2011; Warren, 2012). This is consistent with the findings from the current study, as patient experience advisors are involved in all aspect of the hospital to provide the patient and family perspective, that is sometimes overlooked by employees (Warren, 2012). Further, involving patients and families on advisory committees allows them to have a better understanding of the health care system, which is similar to findings by Halm et al. (2006) and Warren (2012). These authors found that involving patients and families on teams within the hospital increases their understanding of the health care system (Halm et al., 2006; Warren, 2012).

Patient and Family Advisory Councils are common in Ontario hospitals (See OHA, 2013 for complete list of hospitals), and their role is to consult on care experience matters within the hospital (OHA, 2013). In theory, patient and family advisors should partner with health care providers to improve services and should participate in the organizational decision-making processes at the highest level (IAP, 2007; Warren, 2012);

however in practice, these councils have been reported to generally only inform or consult on projects that are linked to the patient experience (Halm et al., 2006; IAP, 2007; Landis, 2007; Piper 2011). Halm and colleagues (2006) describe how their Patient and Family Advisory Council acts only as a consultant, providing recommendations, where the leadership team and administrators make the final decision. These findings are inconsistent with those of the current study and are more aligned to those of Warren (2012), who describes the relationship between the organization and patient and family advisors as a partnership, where they are involved in all aspects of planning and decision-making on improvement and policy initiatives within the hospital. In this study, all employees reported working collaboratively with a patient experience advisor on a project, and the patient experience advisors described how the staff would not consider doing a project without them. This truly demonstrates their level of participation within the hospital setting.

The second strategy used to inspire change is the development of a common PFCC language among employees and patient experience advisors, in order to begin transforming the care environment within the hospital. The definitions provided by the employees and patient experience advisors were consistent with the literature reviewed on PCC. Nurses described looking at the person as a whole or in a holistic way and ensuring that trust was in place (Brown, 1994; Brown, et al., 2008; Carter, 1994; Leplege, et al., 2007; Titchen, 1996), whereas the porter and maintenance worker believed that we should be doing all that we can to help the patient and the family while they are in hospital. This is a more simplistic definition that has not been previously found in the literature. A number of employees and patient experience advisors described PFCC as a

partnership, working together with patients and families, which is consistent with a number of PCC definitions found in the literature (Abdelhadi & Drach-Zahavy, 2001; Agency for Health care Research & Quality, 2005; Coulter, 2002; IOM, 2001; Rogers et al., 2005).

The third strategy used to inspire change in the PFCC process was motivating change among employees through patient narratives. This technique has been used in health care for some time as it is a powerful incentive for change, which increases motivation and compassion, offers insight that resonates with listeners and the audience gains meaning from it (Adams, Robert & Maben, 2015; Perez, Cummings, Schrag, Mead & Jewers, 2013; Conway, 2008; Cornwell & Goodrich, 2009; Gidman, 2013; Wilcock, Brown, Bateson, Carver & Machin, 2003). Patient experience advisors were motivated to tell their stories to encourage change within the health care system, which is similar to findings by Wilcock et al. (2003). Through patient narratives, employees could relate to the story (either as an employee, patient or family member) and in turn wanted to make the hospital a better place. The patient experience advisors were able to demonstrate to employees through narrative why PFCC was worth caring about. This is consistent with the Heath and Heath (2010) framework, which describes that showing people why something is worth caring about, allows individuals to see themselves in a new light, and they will want to start acting accordingly.

The patient narratives provided employees and patient experience advisors with real situations, where they could pinpoint successes and points for improvement. Similarly to the Heath and Heath (2010) framework, people think about three questions: (1) What kind of person am I? (2) What kind of situation is this? (3) What does a person

like me do in this situation? Employees and patient experience advisors within the current study understood their role within the hospital, and wanted to make a difference in the lives of others. As a result, employees developed this internal desire and drive to care for others, and give back to their patients, families, communities, and each other. This unusual level of motivation provides individuals with the ability to act and do what they believe is right; in this case PFCC (Heath & Heath, 2010; Kotter & Heskett, 1997). This allows employees to feel good about working for an organization (Kotter & Heskett, 1997), and they in turn become loyal (Heath & Heath, 2010; Kotter & Heskett, 1997). This is indicative of a strong organizational culture that is high performing (Kotter & Heskett, 1997).

In this second step of the PFCC process, strategies to inspire change are described. The hospital introduced patient experience advisors into various committees, developed an understanding of PFCC, and used patient and family narratives to motivate change among the employees within the organization. Yet, in order to make sustainable changes in health care, the environment must be shaped in a way that encourages the change.

Organizational Structures

The third step in the process is the development of organizational structures that foster PFCC and change. Organizational structures reinforce employees and patient experience advisor behaviours to ensure they make the appropriate choice every time a situation arises. In this case, the hospital empowered patient experience advisors and the leadership team supported PFCC initiatives by engaging employees and patient experience advisors in continuous improvement.

As previously discussed, patient experience advisors were invited into the hospital environment to participate on committees and initiatives. In the current study, not only do patients participate on these committees and initiatives, but families do as well. Including family in the PCC model is relatively new to health care. It was introduced in the last decade and mostly present in pediatric health care (Baas, 2012; Landis, 2007; MacKean, Thurston & Scott, 2004; Mastro, Flynn, & Preuster, 2014). In recent years, other hospitals around the world have begun to include the family in PCC, and have invited them to participate on committees and initiatives throughout the hospital (Baas, 2012; OHA, 2013; The Joint Commission, 2010). Participants in this study explained that the family members know the patient intimately and are able to detect changes in the patient, making family members valuable members of the care team, which is consistent with findings from Frampton et al. (2013). Involving the family in the care planning process allows health care professionals the opportunity to provide better care to the patient and at the same time educate the family (Frampton et al., 2013), which was also echoed by the participants in this study.

A new finding from this study is the engagement of patients and families in the human resource process through interviews with potential candidates for positions within the hospital. This is one of only three hospitals in Ontario that engages patients and families in the hiring process. This new and innovative strategy has been successful for the hospital, as they are now hiring qualified patient and family centred candidates, which ensures that the vision of PFCC is achieved.

The second strategy used as an organizational support is leadership. Strong, committed leadership support has been reported as a key factor in the implementation of

PFCC within the hospital environment (Chassin & Loeb, 2011; Luxford et al., 2011). The leadership team in this leading Ontario hospital has encouraged the involvement of patients and families on improvement initiatives, and has modeled the expected behaviours for employees and patient experience advisors. The leaders in this organization provide their employees with the opportunity to use their knowledge, skills, and talents, as they are the individuals that are on the frontlines (Kerfoot, 1998). These leaders can be described as transformational, as they empowered and motivated their employees through a clear vision, with values and guiding principles, where employees build and foster trusting relationships with patients and families (Bono & Judge, 2003; Chassin & Loeb, 2011; McAlearney, 2006; Schermerhorn & Wright, 2011). Additionally, the leaders incorporated the guiding principles and PFCC in employee performance reviews. This can be seen as capacity building among employees, and has been described as a facilitator in the development of a PFCC culture (Luxford et al., 2011). This management technique allows for open communication among leaders and employees, where they discuss successes and challenges of PFCC (Kerfoot, 1998). The increase in support by the leaders within the hospital motivated employees, as the support and encouragement made them feel valued and proud that they were including patients and families to make a difference.

An interesting concept that emerged throughout the interviews was that employees felt supported in their initiatives by the patients and their families. In turn, this allowed them to feel supported in their roles in providing PFCC within the organization. This is a new finding from the current study, as no literature has been found to support this concept. This demonstrates how the hospital in the current study has developed a

mutually beneficial partnership with patients and families.

The last strategy used to foster a supportive environment conducive to PFCC is an environment where continuous improvement occurs through improvement initiatives and education. Employees and patient experience advisors spoke about LEAN approaches in their improvement initiatives, demonstrating a systematic approach to continuous improvement. Further, the hospital implemented a mechanism for continuous auditing and feedback, where the results are presented to employees and patient experience advisors on an on-going basis. Organizations that are highly reliable encourage a culture of safety through regular reports on safety initiatives in order to reveal problems in the early stages, and communicate those back to the employees, leading to action for change (Chassin & Loeb, 2011). This is also consistent with literature on organizational culture (Schein, 2004, 2010). The hand hygiene audits that are posted are an artifact of the organization. As these audits are presented to employees and patient experience advisors on an on-going basis, this appears to have helped develop shared values and beliefs about the importance of hand washing in practice. In 2009/10, this leading Ontario hospital was the poorest performer in the province for hand hygiene compliance (34%). In 2015, they are one of the best, with a hand hygiene compliance of 90%. This demonstrates how organizational artifacts, when properly used can lead to basic underlying assumptions of an organization. When artifacts, beliefs and values, and assumptions align, this is indicative of a strong organizational culture (Schein, 2004, 2010). Through continuous improvement, this organization has been able to excel in quality and safety, creating a culture of PFCC.

PFCC is also fostered through a culture that is strongly supportive of change and

learning (Luxford et al., 2011). West, Barron and Reeves (2005) found in their study on barriers to PFCC that nurses wanted to be trained in PFCC, more specifically in the areas of social and interpersonal aspects of care. In this hospital setting, continuous improvement is fostered through education and training on PFCC through a peer-to-peer education model, referred to as H.E.A.R.T. program. The H.E.A.R.T. training provides employees and patient experience advisors the opportunity to understand PFCC and associated behaviours, enabling them to utilize those behaviours in practice.

The empowerment of patient experience advisors, leadership support, and a culture of continuous improvement are organizational structures that ensure positive PFCC behaviours are reinforced. This leading Ontario hospital has utilized these strategies, in addition to the guiding principles and motivation for change, to ensure that employees are supported in providing PFCC. Although this leading Ontario hospital presents an overarching process for PFCC, there are still organizational and environmental barriers to PFCC that exist within the care environment.

Organizational and Environmental Barriers

Despite the growing recognition of PFCC as the gold standard of care, the implementation of these day-to-day practices pose challenges both at the organizational and environment level, for even the most committed health care providers and organizations. For this reason, it is important to consider the organizational and environmental challenges of PFCC within each individual health care organization to ensure that the proper solutions are utilized to minimize these barriers. The results of this study describe challenges such as time and resources, PFCC at the system level, recognition of staff expertise and governmental policies.

The first barrier, lack of time and resources, was describes by employees of the organization as too many patients and not enough time to ensure all PFCC needs were met. This finding is consistent with the literature, where lack of time and adequate resources were the main challenges described by staff within the health care environment (Abraham & Moretz, 2012; Conway, Johnson, Edgman-Levitan, Schlucter, Ford, Sodomka, & Simmons, 2006; Coyne, O'Neill, Murphy, Costello, & O'Shea, 2011; Paliadelis, Cruickshank, Wainohu, Winskill, & Stevens, 2005; Pelzang, 2010; West et al., 2005). Employees in this study did not believe that PFCC would have a higher financial cost as was found in the Bamm and Rosenbaum (2008), but rather indicated that they did not have the staff-to-patient ratio necessary to spend more time with each individual patient providing PFCC.

The directors and physicians explained the second barrier from a system perspective. PCC definitions in the literature are varied, yet they all describe care that is centred on the individual patient and family, which is inconsistent with the director and physician perspectives presented in this study. Physicians and directors indicated that PFCC in the care environment does not mean individual care, nor does it mean only treating the individual person at that time and catering to their needs. They described PFCC from a system perspective, as a need to be cognizant of other people in the environment, and providing the right care at the right time. There was a need for balance between all patients in the acute care environment. This unique finding adds to the literature on defining PFCC and indicates the importance of considering all patient and family wants and needs within the system before "catering" to one single patient or family.

The third barrier is also a unique finding from the current study. Employees in the hospital described sometimes not being consulted in their area of expertise, and feeling forgotten during decision-making. As such a PFCC hospital, the organization is extremely focused on hearing the patient and family voice. In health care organizations, it is important that decisions are not solely developed using the top-down approach, nor the bottom-up approach, as it leads to resistance from staff or lack of support from leadership (Coyne et al., 2011; Desmidt et al., 2009; Pelzang, 2010). The analogy in this case is the idea of pendulum swing and balance between patients, families and employees. The organization in the current study is very focused on patients and families at the detriment of the employees not feeling prioritized, and as though they are heard by the organization. In order for the relationship between patients, families and employees to be successful it is important to find the appropriate balance, where both parties are included equally at the appropriate time.

Finally, the fourth barrier to PFCC outlined by the staff is environmental challenges. This is described as the gap between benchmarks, policies and PFCC. The specific example provided is ALC guidelines in regards to of length of stay, and being pressured to discharge the patient even though the patient may have expressed that they do not feel ready to go home.

PFCC challenges still exist within the care environment and can have detrimental effects on patient quality of care and satisfaction. When implementing new policies or practices at both the government and organizational level, it is important to align these policies with PFCC goals, in order to ensure the new initiatives do not detract from current PFCC initiatives.

Reflection and Improvement

The last step in the PFCC process is reflection and improvement. Employees and patient experience advisors describe a hospital that is governed by patients and families, where PFCC is ingrained in the practices of the organization (Carroll & Quijada, 2004; Fitzgerald & Desjardins, 2004), which is consistent with organizational culture and change (Schein, 2004, 2010). The PDoV is an artifact of the organization. Attaching tangible behaviours (i.e., guiding principles) to each of the principles helped prepare the hospital environment for change. Strategies that were used to support the guiding principles included: inspiring change (i.e., patient experience advisors, defining PFCC, and patient narratives) and a supportive environment (i.e., empowering patient experience advisors, leadership support, and continuous education and improvement). This allowed employees and patient experience advisors to understand the direction of the organization and inspired them to create change. These strategies helped foster PFCC values, and promote the ideologies of the employees and the rationalization of their behaviours (Fitzgerald & Desjardins, 2004; Schein, 2010). This led to the development of assumptions, the third and deepest level of organization culture (Carroll & Quijada, 2004; Schein, 2010), thus creating a positive PFCC culture change. PFCC change can also be measured by their 95% satisfaction rate with quality of care from 2010-2015, which was an increase from previous years.

As the hospital continues on their PFCC journey, an important finding from this study is that employees and patient experience advisors describe this as the beginning of their journey, and the need to ensure that the organization is continuously evolving to meet the needs of patients and families. This is consistent with the literature on highly

reliable organizations (Chassin & Loeb, 2011; Luxford et al., 2011) that encourage innovation and continuous improvement within the organization.

This last step describes a PFCC culture change within an acute care organization. In five years the hospital has created a direction, inspired their employees, patients and families, as well as incorporated organizational structures to encourage PFCC. Although this is a PFCC culture change, individuals within the hospital recognize that organizational and environmental barriers exist, and solutions must be developed in order to continue being leaders in PFCC.

Chapter 6 – Conclusion

In 2010, the Ontario government adopted the ECFAA to improve PCC in Ontario health services. This study is the first of its kind to examine how the PDoV, a component of the ECFAA, was used in policies and practices. The findings of the current study demonstrate how the PDoV was utilized to inform policies and practices, leading to the development of processes and core strategies to foster PFCC within an acute care organization. In this case, the hospital did refer to and utilize their PDoV to inform policies and practices to improve their PFCC approaches, albeit with an organizational focus on the use of pre-existing terminology and structures.

This leading Ontario hospital utilized the requirement of creating the PDoV to develop guiding principles, which encouraged respect, engagement, accountability, transparency, and value for money within the care environment. The associated behaviours ensured that employees and patient experience advisors knew what was expected of them. Patient experience advisors were introduced to inspire employees, help them understand PFCC, and motivate them to change. By empowering patient experience advisors, increasing leadership support, and implementing continuous improvement, the guiding principles were reinforced and the hospital's mission to provide outstanding PFCC is being realized. This led to an unusual level of motivation and commitment among employees and patient experience advisors, which is consistent with characteristics of a high-performing organization, and thus resulted in a culture shift.

Limitations

There were three main limitations to the current study including the participant sample, the hospital case selected, and the method of data collection.

Participant Sample. The first limitation is the participant sample. Interviews were conducted with the CEO, PFCC lead, directors, managers, a physician, a nurse practitioner, nurses, allied health, PT/OT, a maintenance worker, and a porter. Although interviewing participants in multiple job roles, and from multiple departments within the hospital allowed for maximum variation sampling, several job roles (i.e., business clerk, personal support worker), as well as departments within the hospital were not included in the study sample. For this reason, valuable information from other job roles, and within other departments was not captured, and could not be included to provide a truly holistic picture of the operationalization of the PDoV.

Hospital Case. The second limitation is the selected hospital case. Although the hospital was selected through a purposeful sampling technique and a rigorous process for selection was utilized, during data collection, it was noted that the hospital had already begun their consultation process, and had developed their strategy and guiding principles, before the implementation of the ECFAA. For this reason, employees were aware of the strategy and guiding principles, but were not aware of the PDoV.

Method of Data Collection. A third limitation is the method of data collection. Individual interviews, the main method of data collection used in this case study, have specific inherent weaknesses. First, there may have been some distorted responses due to personal bias on behalf of the participants. The organization selected for study has been praised in the media, and in the Ontario health care setting time and time again for their excellence in PFCC, thus the individuals interviewed may have some personal bias towards their excellence in PFCC. Therefore, they may not have spoken about incidences in the hospital where PFCC was not present.

As participants were recruited on a volunteer basis, the individuals who agreed to participate may have been more positive in regards to PFCC, and thus felt more inclined to participate. This may have resulted in limited negative examples of value statement use in the organization. This is a limitation of the current study that could not be avoided due to the ethical obligations of the researcher. Participants cannot be forced to participate, and confidentiality and anonymity must be maintained at all times. For this reason, the recruitment of volunteers was the only feasible option.

Implications

The current study has several implications for research, practice and policy in Ontario. Prior to this research study, no research had examined whether having statements about patient values was linked to hospital policies and practices. Although value statements appeared to be beneficial in the health care setting, there was little practical guidance on how health care administrators should formulate and deploy those mission statements (Bart & Tabone, 1999). Further, prior to this study, there was no guidance on how to operationalize the PDoV in policies and practices. The results are beneficial for managers in the acute care environment. This study provides a five-step process, with 16 core strategies that can be used by leaders and managers to foster PFCC in other acute care organizations. Although Lewin (1952), Kotter (1996), and Heath and Heath (2010) offer change management models, this five-step process is unique, as it is specific to the Ontario acute care environment.

Additionally, Baker and MacIntosh-Murray (2012) conducted the only empirical study addressing the ECFAA, and examined how the Act influenced Ontario health care governance practices relating to quality and safety. This study only addressed quality and

patient safety at the board level. This study adds to the literature on the ECFAA, as it examined how the PDoV, as a component of the ECFAA, was operationalized at the frontline to help advance PFCC within the acute care environment. Further, this study has policy implications specific to the ECFAA. The MOHLTC should require hospitals to develop an action plan that is linked to the PDoV. This would further encourage PCC behaviours within the hospital setting. Hospitals would report to the MOHLTC annually on their PDoV action plan. An action plan would help hospitals move the PDoV past the first level of culture (i.e. artifact), to espoused beliefs and values, and ultimately PCC assumptions and practices.

Finally, this study has policy implications, and highlights the importance of researching best practices and "bright spots" before implementing policies. The ECFAA was developed to help promote PCC within the acute care environment, however, little research was done to understand what leading hospitals in Ontario were already doing to promote PFCC. In the future, the examination of "bright spots" (Heath & Heath, 2010) within Ontario acute care organizations should be studied to understand initiatives that are already underway, that may serve as a guide for other health care organizations.

Future Directions

This section provides three main areas for future direction. The first is to conduct additional research on the how the processes and strategies outlined, in figure 5, are implemented in another acute care hospital in Ontario. The purpose of the study would be to determine if the processes and strategies could be implemented in a similar setting, in order to replicate the same results. A similar qualitative study, using a narrative approach might be useful to study the implementation process (journey) of the PDoV in policy and

practice, within a specific case, over time. The results of the proposed study would help determine the effectiveness of the processes and strategies described in the current study, in creating a PFCC culture.

Secondly, hospital administrators should examine the organizational and environmental barriers to PFCC (i.e., time and resources, policies, staff engagement) that exist within the care environment. For instance, a barrier to PFCC that was described in the current study was PFCC from a system perspective. Physicians and directors described PFCC from a system perspective, rather than from an individual patient perspective, which is inconsistent with current PFCC definitions. A second study should be conducted to examine PFCC from a system perspective. This study could be conducted across multiple hospital sites, through observations and interviews with employees and patient and family advisors, to understand how factors of equity and equality are affected by PFCC from an individual and system perspective. The findings from the proposed study would add to the body of literature on PFCC definitions, and the operationalization of those definitions in practice. Identifying barriers to PFCC will allow employees, and patients and families the opportunity to address barriers prior to the implementation of strategic plans. This would also encourage continuous quality improvement initiatives to further promote a culture of PFCC.

Finally, a comparative analysis should be conducted, where the operationalization of the PDoV in multiple hospitals (i.e., high performing and low performing) would be researched and compared to understand the successes and challenges in each type of hospital. The comparative study should be a mixed methods study that examines the operationalization of the PDoV through observations, document analysis, and interviews,

with employees and patient and family advisors, coupled with analysis of performance measures (i.e., patient satisfaction scores, quality improvement indicators, patient safety indicators). The implications of a study of this genre would provide an understanding of how the PDoV has an impact on hospital performance, while providing hospital administrators with various strategies that foster PFCC cultures in different types of health care settings.

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Appendix A – Description of the Excellent Care for All Act Components

Component	Description
Quality Committee	The quality committee is responsible for monitoring and reporting to the board of directors on quality issues and on the overall quality of services provided in the hospital setting (Matthews, 2010). Furthermore, they are responsible for the knowledge exchange of materials to all employees, patients, and caregivers in the hospital (Matthews, 2010). Finally, they are responsible for the oversight of the preparation of the annual quality improvement plan (Matthews, 2010).
Surveys	The ECFAA states that surveys to patients, and patients' caregivers, as well as, employees need to be conducted annually to collect information about satisfaction with the services provided (Matthews, 2010).
Patient Declaration of Values	The ECFAA indicates that every hospital needs to develop a Patient Declaration of Values (PDoV) through a public consultation process. The values obtained through consultation with the public need to be made available to the public (Matthews, 2010).
Patient Relation Process	The patient relations process, is a process to address patient, client, and caregiver relations. This process must reflect the PDoV, and be available in every hospital (Matthews, 2010).
Annual Quality Improvement Plan	The quality improvement plan must be developed using the results of the survey data, related to the patient relation process, and must contain annual performance improvement targets and the justification for those targets (Matthews, 2010).

Performance Based Compensation	The ECFAA requires hospitals to ensure that the payment of compensation for any executive of the organization be linked to the achievement of the performance improvement target set out in the quality improvement plan (Matthews, 2010).

Appendix B – Letter of Invitation to Quality Experts in Ontario

September 30th, 2014,

Principal Investigator: Dr. Madelyn Law, Associate Professor, Department of Health Sciences, Brock University

Student Principal Investigator: Miss Erica Bridge, MA Candidate, Department of Health Sciences, Brock University

Dear [Review Name],

I, Dr. Madelyn Law, Principal Investigator, and Miss Erica Bridge, Student Principal Investigator, from the Department of Health Sciences, Brock University, invite you to participate as a quality expert consultant in a research project entitled *Examining the Influence of the Patient Declaration of Values on Hospital Practices and Policies*. The purpose of this research is to explore how the Patient Declaration of Values is in fact operationalized in practices and policies in the hospital setting.

In order to complete this review I have included in this email the following documents and details:

Qualitative Form
Section 1: An overview of the study and reviewer instructions
Reviewer's Form
The template to be completed for the review

Thank you for taking the time to be involved in the review of Ontario hospitals for this Master's project.

If you have any questions during this review please feel free to contact me at my email mlaw@brocku.ca, eb09jo@brocku.ca or (905) 688-5550 ext 5386.

Thank you and I look forward to reading your review of Ontario Hospitals!

Best Regards,

Madelyn Law

This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board [REB 14-033].

Section 1: An overview of the study and reviewer instructions

Overview of the study

As demonstrated in the literature, health care costs in Canada continue to increase, while the quality of care remains the same, lending to the dissatisfaction of Canadians in regards to the health care services provided in Canada. In order to address the quality of care issue, the Ontario government adopted the Excellent Care for All Act, which was developed with the patient in mind, and indicated that by improving the health of patients and their caregivers, quality and value in Ontario's health care system would be improved and sustained. The patient Declaration of Values, which is part of the Act is conceptualized as a way to help hospitals continue to put patients first, and move toward a patient-centred care approach, by clarifying what Ontarians can expect from their health care organization. However, to date no research has examined whether having statements about patient values is in fact linked to hospital practices and policies. We are left to question whether Ontario hospitals have referred to and utilized the Patient Declaration of Values when implementing new practices and policies within the organization. Therefore, the purpose of this research project is to explore how Ontario hospitals operationalize their Patient Declaration of Values statements.

Overview of the review process

Your Task
In order to select a hospital site, experts in the field, such as yourself, will be asked to provide a list of three high-performing hospital organizations that you view as leaders in patient-centred care and the Patient Declaration of Values. You will be requested to rank the organizations from one to three, with one being the most successful organization at the operationalization of patient-centred care and the Patient Declaration of Values in practice and policy. This is the first step in the site selection process. The review that you provide will allow the researchers to create a rank-ordered list of the most successful hospitals, in order to contact a leading hospital to participate in the research study to understand how the Patient Declaration of Values is in fact operationalized in practice and policy. Once one site has been secured for the study, 15-20 employees in various roles in the organization will be invited to participate in the study. In order to help you develop a list of hospitals that are leaders in patient-centred care and the Patient-Declaration of Values, please use the criterion provided in the "Reviewer's Form" to guide the process.

Privacy and Anonymity
The rank-ordered list will remain anonymous and will not be made publicly available. Your name will not be attached to the list, nor will it be mentioned in any publicly available documents.

Timelines
Although the timeframe is flexible it would be appreciated if all of these tasks could be completed by October 1st, 2014.

Section 2: Reviewers Form
***Please complete this form on your computer and return to eb09jo@brocku.ca.*

Reviewer Name:

Guiding Criterion:

Are the hospitals located in Ontario?

Are the hospitals viewed as leaders in patient-centred care by their peers?

Has the Patient Declaration of Values been actively used in the organization?

Has staff dedicated/accountable to the development of PCC approach in the organization?

Has patient-centred care been seen as a strategic priority in the organization?

Are the hospitals engaged in many patient-centred care activities such as research, workshops and conferences?

List of Hospitals in order (1=highest performing organization):

1)
2)
3)

Appendix C – Letter of Invitation

Examining the Influence of the Patient Declaration of Values on Hospital Practices and Policies

October, 2014

Principal Investigator: Dr. Madelyn Law, Associate Professor, Department of Health Sciences, Brock University

Student Principal Investigator: Miss Erica Bridge, MA Candidate, Department of Health Sciences, Brock University

I, Dr. Madelyn Law, Principal Investigator, and Miss Erica Bridge, Student Principal Investigator, from the Department of Health Sciences, Brock University, invite you to participate in a research project entitled *Examining the Influence of the Patient Declaration of Values on Hospital Practices and Policies.*

As demonstrated in the literature, health care costs in Canada continue to increase, while the quality of care remains the same, lending to the dissatisfaction of Canadians in regards to the health care services provided in Canada. In order to address the quality of care issue, the Ontario government adopted the Excellent Care for All Act, which was developed with the patient in mind, and indicated that by improving the health of patients and their caregivers, quality and value in Ontario's health care system would be improved and sustained. The patient Declaration of Values, which is part of the Act is conceptualized as a way to help hospitals continue to put patients first, and move toward a patient-centred care approach, by clarifying what Ontarians can expect from their health care organization. However, to date no research has examined whether having statements about patient values is in fact linked to hospital practices and policies. We are left to question whether Ontario hospitals have referred to and utilized the Patient Declaration of Values when implementing new practices and policies within the organization. Therefore, the purpose of this research project is to explore how Ontario hospitals operationalize their Patient Declaration of Values statements.

As a stakeholder in the Patient Declaration of Values, and patient-centred care, your hospital has been nominated by quality experts in Ontario to participate in this study, as you are a high performing hospital that values patient-centred care. Thus, we would like to understand the perception of your employees in regards to the utilization of the Patient Declaration of Values in practice and policy within your hospital. Should your hospital choose to participate, your employees (15-20) will be asked to participate in individual interviews that will take approximately 30 minutes during paid working hours. The interviews will take place in a quiet hospital research office or at a location chosen by the participant. The data collected will remain confidential, thus hospital administrators will not know who participated and will not have access to individual participant's comments.

In order to identify employees in various job roles, and departments, your organization will be required to submit a contact list of 90 employees (i.e., professional emails), from which 15-20 employees will be selected for interview, in order to ensure anonymity and mitigate possible social risks (i.e., loss of status).

There are no direct benefits to you as a participant. However, the potential benefits to the scientific community will be an enhanced understanding of the Patient Declaration of Values is operationalized in practice and policy, which can be transferred to other hospitals to allow for the development of more effective and efficient health services for the community.

Privacy and confidentiality of data will be ensured as your organization's name will not be used in the reporting of data, and pseudonyms will be used when using employee quotations. The only identifying information that will be used is the employee's job title in the reporting of results. This information will be linked to the data as it will be important to assess whether there are differences between profession's view of the operationalization of the Patient Declaration of Values in practice and policy.

If you have any pertinent questions about your rights as a research participant, please contact the Brock University Research Ethics Officer (905.688.5550 ext. 3035, reb@brocku.ca).

If you have any questions, please feel free to contact me (see below for contact information).

Thank you,

Madelyn Law, Ph.D.
Assistant Professor, Principal Investigator
(905) 688-5550 ext. 5386
mlaw@brocku.ca

This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board [REB 14-033].

Appendix D – Document Summary Form

Site:_____
Document:_____
Date reviewed:_____

Name or description of the document:

Event of contact, if any with which document is associated:

Date:_____

Significance or importance of document:

Brief summary of contents:

Other supporting documents that are linked to this particular document:

Appendix E – Interview Guide

Introduction

EB: *Thank you for taking the time to participate in my study. I am very appreciative. Before we being the interview, I would like to tell you about my research study. I am currently a graduate student at Brock University pursuing a Master's degree in Community Health Sciences and I am interested in the field of patient-centred care in the hospital setting. I want to learn about the Patient Declaration of Values, more specifically focusing on how it is operationalized in practices and policies in the hospital. It is my hope that I can continue to conduct research on effectiveness and efficiency of patient services in the health care sector. I want you to know that you are not obligated to answer any of the questions that may make you uncomfortable. I hope that this can be a relaxed conversation between two individuals. Do you have any questions or comments before we begin? The first thing I would like to talk about the development of the Patient Declaration of Values.*

Section 1: Background Information

1. Are you familiar with the Patient Declaration of Values?
    a. Probe: If yes, continue asking the background information questions, and use the term Patient Declaration of Values
    b. Probe: If no, do not ask the background questions, and continue the interview using the term "patient values" instead of Patient Declaration of Values
2. How did you first learn about the Patient Declaration of Values?
3. Were you involved in the development process?
    a. Probe: If yes, can you tell me how you went about developing this statement?
    b. Probe: If yes, who participated in this process?
    c. Probe: If yes, what was your role in the development process?
    d. Probe: If no, do you know who was involved in the process?
4. Once the Patient Declaration of Values was developed, how was it distributed throughout the hospital?
    a. Probe: Who distributed it?
    b. Probe: Where was it placed?
    c. Probe: What is its role?

EB: Thank you for sharing with me. I would like to talk about ways that your hospital operationalizes the Patient Declaration of Values in practice and policy.

Section 2: Patient Declaration of Values in Practice and Policy

EB: I am going to present to you a copy of the Patient Declaration of Values. Can you please have a read through the document?

1. Tell me in your own words what the Patient Declaration of Values means to you?

    a. Probe: How do you interpret/understand the Patient Declaration of Values?
    b. Probe: Can you describe the similarities and differences of the Patient Declaration of Values in comparison with the existing organizational culture and policies (i.e., does it align to the QIP, strategic plan)?
2. Do you consider yourself a key stakeholder in the implementation of these patient values?
    a. Probe: If yes, how so?
    b. Probe: If no, why not?
3. Are you able to use the content of the Patient Declaration of Values as a point of departure for decision-making and acting in your daily routines?
    a. Probe: Could you provide me with an example of how you have used the Patient Declaration of Values in everyday practice?
4. Do you believe that the Patient Declaration of Values has been implemented in the practice and policy environment of this hospital?
    a. Probe: If yes, can you provide me with an example?
        i. Probe: How was the Patient Declaration of Values used as an impetus for the practice/policy implementation?
    b. Probe: If no, how could this Patient Declaration of Values be implemented in the practice/policy environment of the hospital?
5. Are there any hospital documents (i.e., strategic plans, new policies, new practices) that have been developed in relation to the Patient Declaration of Values?
    a. Probe: If yes, which ones?
    b. Probe: If yes, how was the Patient Declaration of Values used as an impetus for the practice/policy document?
    c. Probe: If not, how could the Patient Declaration of Values be used in the future to inform practice/policy documents?

EB: *Thank you for sharing with me. I would like to talk about patient-centred care in the hospital setting.*

Section 3: Patient-Centred Care

1. What does patient-centred care mean to you?
    a. Probe: Are there any values that you attribute to patient-centredness?
2. What is your role in providing patient-centred care to patients?
3. Since the implementation of the Patient Declaration of Values, has this influenced patient-centred care behaviours in your hospital setting?
    a. Probe: If yes, can you provide an example?
    b. Probe: If no, how could this patient value statement be used to inform patient-centred care behaviours?

Conclusion

EB: *Again, I want to thank you for participating in this study. The information that you have shared with me will be extremely helpful in understanding the Patient Declaration of Values and patient-centred care. Is there anything that you would like to add to our conversation that I did not cover? Do you have any questions or comments? I will send you a copy of the transcript and a copy of the main themes of the project when it is complete to give you the opportunity to check for accuracy. Please contact me via e-mail if you have any questions or concerns.*

Appendix F – Informed Consent

Date:

Project Title: Examining the Influence of the Patient Declaration of Values on Hospital Practices and Policies

Principal Investigator: Madelyn Law

Dr. Madelyn Law, Associate Professor, Department of Health Sciences, Brock University, (905) 688-5550 ext. 5386, mlaw@brocku.ca

Student Principal Investigator: Erica Bridge

Miss Erica Bridge, MA Candidate, Department of Health Sciences, Brock University, eb09jo@brocku.ca

INVITATION

You are invited to participate in a study that involves research. Your organization provided a list of 90 employees in various job roles and departments, and you were 1 of 15-20 employees selected for interview. The purpose of this study is to explore how the Patient Declaration of Values influences the practices and policies in the hospital setting, and as an employee of the hospital your role in the operationalization of the Patient Declaration of Values is critical to understand, and will inform future practices and policies.

WHAT'S INVOLVED

As a participant, you will be asked to participate in an individual interview session that will take approximately 30 minutes of your time. The interviews will take place in a private research office in the hospital, which will protect privacy and confidentiality. Your interview will be audio recoded for transcription purpose. This study is a single site project including approximately 15-20 participants.

The purpose of the interview is to understand how patient values and the Patient Declaration of Values is operationalized at all levels in the hospital settings, more specifically in hospital practice and policies. The interview questions will resemble a guided conversation, and will highlight (a) your role in the development of the Patient Declaration of Values, (b) how the Patient Declaration of Values was distributed in your organization, (c) what the Patient Declaration of Values means to you, (d) how you implement patient values into every day practices, d) how you use the statement for decision-making, and (e) how it contributes to patient-centred care in your hospital.

As a participant in this study, you will have the opportunity to participate in the member check process. Member checking is a process where the researcher presents the description and the conclusions of the data collected. Member checking will occur once the data has

been analyzed and interpreted. The results that emerge from the interviews will be sent to you in an email in order to allow you to confirm the findings and make sure that the data is properly interpreted.

POTENTIAL BENEFITS AND RISKS

There are no direct benefits to you as a participant. However, the potential benefits to the scientific community will be an enhanced understanding of how the Patient Declaration of Values is operationalized in practice and policy, which can be transferred to other hospital patient to allow for the development of more effective and efficient health services for the community. To minimize the social risks (i.e. loss of status, reputation or job) of this study, 15-20 individuals were selected from a list of 90 possible individuals to ensure anonymity, pseudonyms will be used, the interviews can be conducted off site, they will be provided with informed consent, and will be given the opportunity to withdraw at any time with no consequences. We believe that this risk is minimal as the site was chosen as a leader in this area and we will be asking participants questions that reflect a positive framework and not addressing major deficits in the organization.

CONFIDENTIALITY

The information that you provide will be kept confidential. Your name will not appear in any report resulting from this study; however, with your permission, anonymous quotations linked to your job title may be used. However, the results will reflect aggregate groupings of commonly discussed ideas from the interviews by way of overarching categories and themes identified by everyone involved in the study.

Data collected during this study will be stored in a locked research cabinet in Dr. Madelyn Law's office. Data will be kept for seven years, after which time all transcript hard copies will be shredded and computer files deleted.

Access to this data will be restricted to Dr. Madelyn Law and Miss Erica Bridge.

VOLUNTARY PARTICIPATION

The organization is aware of and supports this research, however employees are not obligated to participate simply because their name was initially selected by an administrator. Participation in this study is voluntary. Your employer will not know who chooses to participate, will not have access to individual participant's transcripts and participation will have no impact on employment at the hospital. If you wish, you may decline to answer any questions. Further, you may decide to withdraw from this study at any time and may do so without any penalty. To withdraw from the study you may contact Dr. Madelyn Law or Miss Erica Bridge at the contact numbers provided above, and audio files and transcripts will be deleted from hard drives, and any hard copies of the transcripts will be disposed of appropriately.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. Feedback about this study will be available in a report form that will be emailed to you at your request. The approximate date of the final results and report completion is September 2015.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please **contact Dr. Madelyn Law** using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University [REB 14-033]. If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 ext. 3035, reb@brocku.ca.

Thank you for your assistance in this project. Please keep a copy of this form for your records.

CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that the interview will be audio-recorded. I understand that I may withdraw this consent at any time.

Name: _____
Signature: _____
Date: _____

RESEARCH RESULTS AND REPORT REQUEST FORM

Note: This form will be kept separate from consent form and interview data to ensure confidentiality.

Feedback will be provided in the form of a review outlining main findings from the study.

I would like to receive the report with the results of this study. You may send this report to the email below:

Email: _____

Appendix G – Contact Summary Sheet

Site:_____
Contact Date:_____
Today's Date:_____
Written by:_____

Contact type:
Visit_____
Phone_____

1) What were the main issues or themes that struck you in this contact?

2) Summarize the information you got (or failed to get) on each of the target questions you had for this contact.

Question	Information

3) Anything else that struck you as salient, interesting, illuminating or important in this contact?

4) What new (or remaining) target questions do you have in considering the next contact with this site?

Appendix H – Brock University REB Application

Brock University
Research Ethics Office
Tel: 905-688-5550 ext. 3035
Email: reb@brocku.ca

Social Science Research Ethics Board

Certificate of Ethics Clearance for Human Participant Research

DATE: 9/8/2014

PRINCIPAL INVESTIGATOR: LAW, Madelyn - Health Sciences

FILE: 14-033 - LAW

TYPE: Masters Thesis/Project STUDENT: Erica Bridge
SUPERVISOR: Madelyn Law

TITLE: Examining the influence of the Patient Declaration of Values on hospital practices and policies

ETHICS CLEARANCE GRANTED

Type of Clearance: NEW Expiry Date: 9/30/2015

The Brock University Social Science Research Ethics Board has reviewed the above named research proposal and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement. Clearance granted from 9/8/2014 to 9/30/2015.

The Tri-Council Policy Statement requires that ongoing research be monitored by, at a minimum, an annual report. Should your project extend beyond the expiry date, you are required to submit a Renewal form before 9/30/2015. Continued clearance is contingent on timely submission of reports.

To comply with the Tri-Council Policy Statement, you must also submit a final report upon completion of your project. All report forms can be found on the Research Ethics web page at http://www.brocku.ca/research/policies-and-forms/research-forms.

In addition, throughout your research, you must report promptly to the REB:

a) Changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) All adverse and/or unanticipated experiences or events that may have real or potential unfavourable implications for participants;
c) New information that may adversely affect the safety of the participants or the conduct of the study;
d) Any changes in your source of funding or new funding to a previously unfunded project.

We wish you success with your research.

Approved:

Jan Frijters, Chair
Social Science Research Ethics Board

Note: Brock University is accountable for the research carried out in its own jurisdiction or under its auspices and may refuse certain research even though the REB has found it ethically acceptable.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and clearance of those facilities or institutions are obtained and filed with the REB prior to the initiation of research at that site.

Appendix I – Results for Qualitative Data

Theme 1: Setting the Stage

"I know the individuals who were involved in crafting it, the final document, but really, the most important part of this was our Senior Leadership engaged our community, engaged the volunteers, engaged the employees and the physicians, and what does the vision look like for our hospital and making sure that all the time that lens with the patient and their families was on that." (Director)

"Very similar language as values because what I wanted to do was make sure that they were used to guide discussions, decision-making, code of conduct, everything so that people could really know that they were there to be lived." (CEO)

"What we've done is build out how, what are the behaviours associated with that, what do the decision-making processes look like in that, what does interaction with patients on a day-to-day basis look like, what does our policy-making look like?" (CEO)

"What we quickly realized was that we couldn't possibly do that on our own and so we invited patients and families in, and we said, "We are going to make a declaration, a bold declaration that says any decision in our organization, whether it's a material impact on the experience of the patient, the patient will be at the table. We said we are going to figure out how to translate our commitment of no decisions about an experience that affect people without those that are affected at the table, and we started down the path." (CEO)

"It just brings the focus back onto the patient and the family, so that we're moving away from being organizational-centric into being more patient and family-centric, so that we understand that this isn't about us. This is about the patients and the families." (PFCC Lead)

"The strategy is what gave us the muscle to say that this isn't optional. By putting it in the strategy, what the strategy says is that every decision materially impacting the patient experience must have the patient and family as part of that discussion. That's what the strategy points out. That really is where the patient- and family-centered care comes in, is transforming the patient experience. I was able to go to the program councils and say, 'We need to get two advisors on each of the program councils. It's not an option. Our strategy says, so we have to do it.'" (PFCC Lead)

Sub-Theme 1: Respect

"There's a lot of people that show respect to other people in different ways so sometimes you might get it the wrong way. Respect others as you want them to respect you. Everybody should have respect no matter what their religion or whatever like that. Getting back to my role here, I've dealt with many different kind of nationalities and I make them feel as a person." (Maintenance Worker)

“Maybe someone didn’t treat me well, but that doesn’t make it okay that I treat them unwell.” (Occupational Therapist)

“The doctors need to respect the nurses, the front line staff, everybody around the table. I have respect for them, they need to have respect for me.” (Patient Experience Advisor)

“One of them is around making sure that staff are wearing their ID badges, and they need to be in the upper portion of the chest, and nothing covered over with tape or other little stickers, or things of that nature, so they can very clearly see what my name is and what my position is. All staff, all employees in the hospital are expected to do that.” (Program Manager)

“Some of the initiatives that have been taken to ensure that we’re delivering that proper care is putting whiteboards in the patient's rooms so that the frontline providers can write their name on, so the patient knows who is looking after them that day.” (Allied Health)

“Another standard is communication, that the person will introduce themselves and say where they're from and why they're there.” (PFCC Lead)

“I try to walk the walk, so what I do in the morning is I come in really early and I walk through a walk-through. I do a walk-through all day long, but I do a big walk-through in the mornings. I talk to the patients who are in there and their families in the mornings every day, Monday through Friday. I see if they've had any issues or any concerns that went on in the morning, and I check with the staff, and we start a dialogue. (Program Manager)

“Patient feedback. We do that a few times a year on our unit where a patient will come back and say the good and the bad things about their stay on our unit.” (Registered Nurse)

Sub-Theme 2: Engagement

“Engagement is not a one-time thing. It’s not a once a year, you know, when you do your evaluations for staff members or something. It not a one-time deal. It’s a continuous thing that you have to keep going all the time.” (Program Manager)

“Generally, I would say it required a two-way conversation. It’s not necessarily, just asking and waiting for a reply, it also involved an element of interaction, active in nature.” (Director)

“It’s a partnership and it means doing with as opposed to doing for, and making sure that they’re involved in all aspects of care. It’s advocating for our patients and families. It’s keeping them well informed. It’s communicating.” (Program Manager)

“We have to recognize different family abilities, and we have to be careful not to impose out expectations on them. Everybody’s family is different and everybody functions differently.” (Physiotherapist)

“I think sometimes clinicians feel that yes, we need to be patient and family centered, and we have to treat our patients a certain way, but it does go the other way, as well. Patients have high expectations for care. They need to be realistic about their care. They need to be respectful, they need to be participating. A relationship is two ways.” (Occupational Therapist)

“With engagement, I think it's very important not only from an employee, but from an employer to ensure that everybody’s engaged in what we do. Everybody's on the same page and delivering the best care that we can to our patients. If they're not engaged it's finding out why. Is it a lack of information or is it a lack of communication, and helping them to understand what their role is in the hospital and helping them to be a better employee.” (Allied Health)

“Even just the bedside rounds, attending with us while we do our work, sometimes attending with us while we do procedures, having regular conversations to update with family members, patient family members. It happens on a regular basis, a daily basis, and it depends on availability. Unfortunately, some patients don’t have family, so it will not involve them, but as much as possible.” (Director)

“For the first part, it's mainly just developing a relationship with them. Over time, if they come to sort out what has happened with them, we might get more in detail with them about what this means to them and help them to sort out the meaning for themselves as to what has gone on.” (Allied Health)

“I’m going to come in hopefully as someone that the patient sees that I am someone that they can trust, they can speak to easily. I’m going to make it as comfortable as possible, our meeting. I want to engage them. If I’m going to be looking for the information and the things that I need to make their stay as best possible, I need to make sure that I’m the kind of person that they're going to want to trust, want to confide in.” (Registered Nurse)

Sub-Theme 3: Accountability

“I think it’s just that the organization should be accountable for the decisions that they make and the policies and procedures they may and that they are accountable to their stakeholders, essentially, but ultimately to patients and their families in the communities.” (Patient Experience Advisor)

“In terms of accountability, from a patient perspective again, it's just keeping them well informed and making sure that if we say something is going to happen, that we follow through, and that it does happen. If the plan changes, then, it's going back and having the discussion with them to say this is why this is now changing.” (Program Manager)

“To me, I guess that's taking ownership and responsibility for the things that happen and that means the good things and the bad things. If there's an error made, you need to take responsibility for the error, but also, if there is something good that happens then we need to say, 'hey look, this was a good thing and we did it.’” (Registered Nurse)

“You're accountable to be efficient, use your resources wisely, and to follow the protocols and the plans that we've set in place for patient flow, and for treatment.” (Physician)

“Accountability for the clinicians with patients. If they say they're going to do something, it's following through, but also being clear that if they can't offer something, that they're clear and transparent around that. I think there's a patient accountability here, too, especially in an environment like this, because often, yes, patients are here and they're receiving care, but certain elements of care require consent and participation. Something like rehab, rehabilitation, you have to consent and be motivated to participate. Rehab just doesn't happen to you, you have to participate.” (Occupational Therapist)

“From a nursing perspective, so if they have a concern, say an anesthesiologist brought a patient into the recovery room, and they have a concern about the anesthesiologist's practice, they never address the anesthesiologist. They tell somebody else or they'll call me to come and solve the problem for them, and what is happening now is that they lack problem-solving skills, their tools again. They don't have tools out of their toolbox so to speak, and then critical thinking which are pillars of nursing. They really are. They paralyze themselves now where they have a hard time making decisions for themselves.” (Program Manager)

Sub-Theme 4: Transparency

“Putting all your cards on the table, and being forthright in terms of what you bring to the table, what you expect, what your expectations are, and also what is expected or needed from the other side, from various people, stakeholders that are involved in the process.” (Director)

“I feel as though, for them to fulfill this strategy, for there to be true patient centered care, there has to be transparency around the change, the good and the bad. There has to be transparency around why things are being done the way they're being done, and an openness to communicate and have those conversations. I see that transparency as being really honest about the situation.” (Patient Experience Advisor)

“Really, what it is is, a level of trust, and I think that once that trust is established, there is actually, shockingly, a lot of transparency. I feel as though, when I'm in meetings or if I'm even in an interview panel, the conversation is very open.” (Patient Experience Advisor)

“Again, I see that as part of transparency that this is what we’re doing. This is what we’re working on, for better for worse. This month it wasn’t so great. December was terrible, quite frankly. Part of it, as far as documenting. We put it out there. I’m not just going to put all the best results. I want to make sure that people know that we need to clean up our act a little bit as well.” (Registered Nurse)

“I deal with a lot of difficult situations, a lot of conflict. When I really peel a lot of the stuff away, it comes down to people not wanting to be transparent, or they don't know how to

be, even if they're reluctant because they're afraid of a negative outcome. It's supporting people and having those tough conversations, to be transparent." (Occupational Therapist)

"We heard that sort of talk when we first started doing this as well, the concern about "Can we have an open conversation with patients and families are present?" I think we can, but it goes back to that respect piece. Having somebody there who might be listening with a critical ear actually makes people talk in a more respectful way." (Director)

Sub-Theme 5: Value for Money

"We need to be responsible with the money that we're allotted from the government, but also, people forget that the community donates money to our facility. We need to be responsible for how we spend that money, too. We need to let them know how we're spending that money." (Registered Nurse)

"The value for money. It's certainly a very big challenge these days in terms of budgets. All of that stuff. I think we really do ... We put forth business cases for ... We're looking at getting a different piece of equipment that perhaps is more costly, but in the long term, it's going to benefit our patients more so than you can't be too short-sided and you need to look at that, and it's just being accountable. If I were asking for extra staff on a particular shift or if I were asking for different or new and improved equipment, it would have to be being able to justify it." (Program Manager)

"They've introduced Omnicell which it's like new, automated drug cabinets. That's really helped. There's better control because the old ways we were changing so many locks every time like somebody would take a lock home. You would have to change maybe nine locks, maybe 36 keys. That took a lot of our resources." (Maintenance Worker)

"The value for money is with regards to ensuring that the cases start on time and that we finish on time and that we're abiding by the ministerial guidelines, and that the money is spent where it's allocated for those procedures that are funded for it." (Program Manager)

Theme 2: Inspire Change

"I love what I do. I feel valued here, but I also feel value here, in that sense." (Director)

"That's really why a lot of people went into health care industry is you care about people. You want to make a difference. We all come here for the same reason every day, really. The same common goal." (Program Manager)

"Getting back to what we were saying is patients are what make a hospital, right? It's not the staff because if you don't have patients, you don't have a hospital." (Maintenance Worker)

"That's the way I look at it, and that is what makes me do what I do. I want to be that way. I don't want the emergency room to be so big that people are in the hallways for

four days. I don't want that the hospital is constantly in gridlock." (Patient Experience Advisor)

"People have an interest in care. They have an interest in quality care, and they have a real interest in making a difference in the lives of individuals. So those individuals that were patients and volunteered have insight into what it's like. They were really the precursors of patient experience advisors." (Director)

Sub-Theme 1: Patient Experience Advisors

"I have expectations, and I want my hospital to be the best hospital in the region, and I want things to move smoothly, and I don't want patients not being heard." (Patient Experience Advisors)

"In general, I participate in a number of quality improvement project working groups. It has exponentially grown. I have been doing a fair number of presentations. The hospital has been really great. When they're invited to speak, they usually take an advisor with them." (Patient Experience Advisors)
"I'm engaged. I'm heard. I feel we are making a difference. I'm not afraid to say it. I' not afraid to say the piece that nobody wants to say." (Patient Experience Advisor)

"Today, the CEO was in our meeting, and she just said to me, 'What's your thought?' Sort of put me on the spot and I'm like so from that point when the top top is looking at me in a room of 40 people and going, 'What's your thought?' It's like, 'I don't know.' I think the more and more I'm involved, the more and more committees I sit on, the more and more I realize the impact that advisors should make in a hospital." (Patient Experience Advisor)

"I know a lot of them are incredibly intelligent and bring a lot to bear in terms of bringing humanity the hospital. There an amazing group of people that are involved and very active; very intelligent people. We're lucky to have that group. (Allied Health)

"We have patient and family experience advisors on every single committee in this hospital. They are the most powerful group I would say. They are the most powerful committee in this hospital, which is where the power should be is back to the patients and their families." (Program Manager)

"I wouldn't even discourage having a patient family advisor on any committee. I think, again stressing that they do come with a different perspective, that sometimes we don't even consider." (Registered Nurse)

Sub-Theme 2: Defining Patient and Family Centred Care

"What it means is that we collaborate with the patient and the family. In a patient and family centers environment, we're all adjuncts to this person's life. And they, at the moment, are having an illness experience. And so we have to be aware of what, who this person is and what their wishes and preferences are, and to work with them, hand-in-hand to work

through this illness, and help them to engage their own healing abilities to recover. It's more like a partnership than a doing to." (Allied Health)
"There are resting stations, those blue chairs. That was a huge initiative. We were the first hospital in Canada to install those, and that was because people wanted to be independent if they could, but to walk those long corridors with a place to take a break was really important. So it came out of that, and we had someone with a mobility disability help us choose which resting station we would buy, and we bought it." (Director)

"I think nursing looks at the patient in the whole, it's the whole patient. Their life, their experiences they bring with them." (Nurse Practitioner)

"I want to listen to what they expect from me. There needs to be a mutual trust between myself and my patient and their family so that they can respect me." (Registered Nurse)

"It's a no-brainer to be nice to patients. It's your co-workers, and people that you're around , and going the extra mile. For me, the main goal is the patient and the family. If you can make them happy, then everybody else should be happy." (Porter)

"If you don't have patients, you don't have a hospital. We've got to do the best we can." (Maintenance Worker)

Sub-Theme 3: Transforming the People

"Myself, having been a patient here last year, I was able to experience that firsthand having my family being about to be here when I was here. The kind of care that I received was amazing too. It's one thing to being on the opposite side, but when you're actually experiencing it firsthand it makes a big difference." (Allied Health)

"If it's a family member of mine I'd want to make sure that we're getting the utmost service and competent person to be looking after that person, right? Because I would be hurtful if something happened to my mom or dad while they were in here, right? And not knowing that they could've done a better job." (Maintenance Worker)

"That's why we went into health care in the first place. We went into health care to help people and to make a difference. After working for as long as I have, I get up in the morning and think, "What am I going to do today that's going to make a difference and feel good about the work I do." Is the workload huge? Absolutely." (Director)

"Because a lot of good people are probably out there that we don't even know about until they -- Honestly, I feel good about myself. I know I could make a difference every day no matter what it is, little or small, I know I'm making a difference and I can say I did a good day's work." (Maintenance Worker)

Theme 3: Environmental Supports

"You need to make sure that you're creating that environment of people that want to do

it." (Patient Experience Advisor)

"It's a really wonderful environment to work in. I enjoy it and just being part of the process." (Allied Health)

"It's evident that we're really listening to what patient and families are saying in the way that our environment has changed." (Director)

Sub-Theme 1: Ultimate Patient/Family Engagement

"They know the patient better than all of us. We can read anything we want about this patient, but they know them. They know this person." (Program Manager)

"Involve family in the history-taking, in the decision-making, in the treatment plan, and everything like that." (Physician)

"We have no visiting hours so the family can be there all the time. The patient's family can stay with them in the room overnight if they have to." (Allied Health)

"After surgery, the staff are told that once the patient is stable and they're fine, that they cannot deny that family access to that recovery room. All the families are welcome in there. We cannot deny them. Most families want to see their loved one and to know that they're safe and everything is okay and then they're happy to go, but you cannot tell them they can't come in because this is their hospital." (Program Manager)

"I think also it really helps with them have a better understanding of the challenges that health care professionals face. There are challenges. There are resource challenges, and just the tough dynamics of the complexity of the issues that we deal with. There's not just a quick answer all the time, it's a process that I think having them at the table allows them to be more aware." (Occupational Therapist)

"What happens when you do engagement well and when patients and families are sitting at every decision-making table, there's nothing that's hidden. It's completely transparent, so they understand the struggles. They understand when things go well, and they understand when things don't go well." (PFCC Lead)

"That is easy because many of the decisions that you have to make have to involve the patients. They have to agree to it. If they're not going to agree to this is the plan, they're not going to do it. There's usually something missing or information that they don't know or there's some gap or they want to do it in a different way." (Nurse Practitioner)

"As I said, often the patients are not in a position to make decisions from themselves, byt the time they get to us, we involve the family. The family needs to be trained that the decisions they are helping us with are not what they would want, it's what they family member would want, and it's a very different perspective. Some of them need coaching around that, to ensure that they are making decisions based on what their husband or wide

would want, as opposed to what they would want so we continue to reinforce that." (Director)

"That document needs to come at the very beginning. When you are starting to work on this document, we have to have our input. It has be changed, so something as simple as the menus that went out for the hospital, they must have come back nine times, because we don't just stamp things for the sake of stamping them. You can't just say, 'Oh, here it is, this is this document, it's done,' and you're like, 'Mmm. I have probably 12 people that are going to rip this apart.'" (Patient Experience Advisor)

"Two years ago when I started at here we had just introduced the patient experience advisor into the interviewing process. We realized that to have a patient's voice in the interview process was something different, something new. It was important for them to be able to meet potential candidates, potential future employees and be able to have that impact to them right at the very beginning to help them understand our model of patient and family centered care." (Allied Health)

"What we do instead is we talk about patient/family centred care in the interview and making sure that anyone that we bring onboard understands our philosophy around patient and family centred care." (Director)

"When you start doing that, then you stop people at the front gate who can't get it. The advisors really, HR is very interested in, where did you go to school? What's your experience? The advisor wants to know, how are you going to show me compassion and empathy? Even if it's an IT person, the advisor wants to know, how is this position going to make a difference to the patient experience? How are you supporting the patient experience? Asking them, do they have an understanding of the importance of their job to the patient experience, making that link for them." (PFCC Lead)

Sub-Theme 2: A Support System

"That's the extent with staff, too. If there's a change or something that's coming down, and you know they're not going to ... You're anticipating they're not going to like it, or think there might be barriers or concerns that are raised, it's them having an opportunity to share what those concerns and questions are, try to clarify, answer questions. Maybe with what's brought forward, maybe you might be able to integrate some of that feedback into the change, but giving engagement, I think, is giving a form or an opportunity to give feedback and so on." (Occupational Therapist)

"So it's providing them with that feedback so that they know. When we get compliments from our patients, it's really, really important that staff know about that. Sometimes, they will specifically mention a specific nurse. In that case, then, I will certainly bring that forward to that staff member, give him a copy, but I'll also put a copy of it filed as well so that's really nice. When it comes directly from the patient, there is no higher compliment than that. Firstly, there will be times when we also get concerns from patients. You know my call bell was on excessively long period of time, no one answered it, or when a certain

individual came, they seem to have a real attitude and didn't want to be at work that day. Those kinds of things, so you share the good with the bad, right?" (Program Manager)

"Absolutely. Our model of care is driven by our leaders and we see them model that every day. They are fully supportive of us as employees being able to deliver that and provide that type of care." (Allied Health)

"It's when senior management is supportive, I think is almost key to success, is having that senior level, not necessarily CEO, but definitely in a VP, director level, having that support for you advisors is a crucial piece to really bring it up to the quality improvement level." (Patient Experience Advisor)

Sub-Theme 3: Continuous Improvement

"That ties back to the LEAN initiative as well. Just to make sure that we're on track doing what we need to be doing without overdoing what someone else is doing." (Registered Nurse)

"What we did was, we picked a champion from literally every piece of the hospital. IT, Nutrition, everybody was represented. I think we had 60 people all together that showed up for a day. The Georgia folk worked with them to have a better understanding of what patient- and family-centered care is. Their task was to go back to their areas of expertise and to choose a project that would be patient- and family-centered from their perspective." (PFCC Lead)

"You would do administrative things like participating continuous improvement. Another role is education and education is educating patients and their families and other callings. Which would include anybody. PT/OT, nursing students, physicians. It's both for your colleagues and education. I also participate in corporate education of new initiatives." (Nurse Practitioner)

"It's reported back to the board, so I'm reporting back to the board on the Q3 results from the audits this Thursday. Nobody wants to be the poorest performer in the hospital. It's all out there. You know all of the units. It's unit-specific, and it's corporate, also, so we roll it all together and have a corporate compliance rate, but I can tell you what each unit compliance rate is also, so that people want to ensure that they're doing the best." (PFCC Lead)

"Each of the nine programs is responsible for holding two feedback forms a year, and a total of four PDSA cycles to come out of them, the Plan-Do-Study-Act cycles and lean methodology. What they do is, they identify a patient or family who have recently been discharged from their unit. They approach them and ask them if they would come back and share what that experience was like with staff. We support them." (PFCC Lead)

Theme 4: Organizational and Environmental Barriers

“There's certain things like, "Why do we have to go to Ottawa to get a PET scan? Why can't we have a PET scan here?" Ninety-seven percent of the time, it comes down to dollars and cents. Let's be honest.” (Patient Experience Advisor)

“So what do we do now is you come in, you get assessed quickly, you get your tests ordered, get seen by a physician. If you don't need to be on a stretcher, you're in a chair somewhere, in a hallway, or back in the waiting room, or somewhere else, and the next person gets seen quickly as well. It's not patient-centered care to let somebody sit in the waiting room in pain for hours.” (Physician)

“We have many many examples still at the system level where we're not patient-focused so we are going to continue to chip away at those with our partners to uphold our values and beliefs in a very concrete way.” (CEO)

Sub-Theme 1: Time and Resources

“I think it's being cognizant of that's what's happening for staff, and so you have, with the tsunami of the elderly coming through, those issues, those social determinants of health, are there, and they're not going away easily. You just have more patients with less resource. It's a tough field, health care.” (Occupational Therapist)

“There's definitely a state of burnout in that regard, but it's also to the complexity of the issues coming in for patients. A lot of the ... Really around the social determinants of health, often their medical issues are a quick fix. It's all the other stuff. They don't have housing, they have no money, they're alone, they're isolated.” (Occupational Therapist)

“I want to do the care that's necessary. You recognize that they deserve it and they need it. That's why they're here, but I physically can't do it. Then you worry about burnout. People get sick which just escalates the problem for others.” (Registered Nurse)

“Again, if it requires personnel and time, that's always a problem in acute care for sure. I know the numbers of personnel has been reduced and reduced and reduced. Certainly nursing staff have those kinds of skills, but if there's not enough of them to have a direct interaction with the patient for more than five minutes then it can be kind of tricky.” (Patient Experience Advisor)

Sub-Theme 2: PFCC on the Frontline

“It’s okay when you get into the department as a patient to receive good care; but if that good care took you 4 hours sitting in the waiting room to get, that’s not right.” (Physician)

“I think the trust in that is patient-centred care is not just the patient in front of you. It’s the patient that’s in your waiting room; it’s the patient that’s downstairs in emerg that you see upstairs; it’s the patient that can’t get transferred in. Your patients are not just the ones in front of you. It’s the ones you can’t see. It’s the next one to come in. That’s what patient care should be all about. That’s what patient-centred care should be all about.” (Physician)

“When I look at [hospital] stating that they do this excellent patient care ... Yes, only in one aspect. The individual patient, that might be true; for the number of people that they have to treat and put through, they fail miserably.” (Physician)

“We have to be cognizant of the other people in the environment. We limit the number of people that can come in and that has to do with safety and confidentiality as well, not just the patient, but the patient in the next bed. We can’t have too many people coming in at once; it interferes with the care of other patients.” (Director)

“One of the challenges is taking it from this level, the CEO, senior level, and embedding it at the bedside. That's something that we're working on now, and is really, really important. It's getting passed the sense that the patient's always right, and getting people to understand that's really not what it is. It's not about the patient's always right. It's about you have to know your patient, to be making the decisions.” (Patient Experience Advisor)

Sub-Theme 3: Excluding Staff

“We had some really interesting feedback from nurses who said, "How come you're listening to the patients and you're not listening to me?” (PFCC Lead)

“That's the challenge of it, is how do we continue to be engaged. How do we continue to ensure that volunteers as ambassadors to the hospital have the ability to articulate change, articulate exciting news, share with others in our community about what we're doing and what we're all about.” (Director)

“Patients and families, patients and families. Well, where do I fit in with that?” (Program Manager)

“Exactly. I think that's really important. It is two very different perspectives, two very different visions, but from our background and from what we’ve experienced, the information that's provided on this piece of equipment will absolutely help our patient when they come in. It’s human nature, right? Sometimes when people aren’t maybe welcomed or onboard at the onset of something, maybe feelings get hurt. I don't know. I don't know. Then it gets to be a bit of, “Well, I’m just going to make an example of this.” Not sure if that's what's happened here, but I do feel this sense of frustration with my co-worker. I’ve seen the finished product. I’m scratching my head thinking, “Why are we not using these?” It’s just a bit frustrating.” (Registered Nurse)

“Bed map means a way that we’ve changed where our patients are. That unfortunately has had a significant impact on the nursing staff. Right when we’re chock full to the brim, unlicensed beds that are open, and they've cut staff on two incredibly busy floors.
I really feel that was handled quite poorly. I feel that even through the staff knew that that was happening, it certainly did, as I said, change the complement of these very busy floors. I feel that we could have done a better job to communicate that. That's where the transparency fell down. As a result that does have an impact on our patient care. That's

not fair to anyone. It's not fair to the staff and ultimately not fair to our patient and family when nurses are stressed. I don't know even how anyone does it in a day anyway." (Registered Nurse)

Sub-Theme 4: Environmental Challenges

"Yes, you're doing a good thing for the patients right in front of you, but you have to make sure that when that patient's ready for discharge, they're out the door by 11, the bed's cleaned immediately, and you get the next patient up within an hour." (Physician)

"There is a consciousness. That's a hard one to give value for money in a provincially-funded hospital if you know what I mean. It's very hard to bring that in to the upper consciousness of people, but it is there. It's there constantly. Just in little ways it's reminders of what we're doing and how it impacts on care." (Allied Health)

"They don't really have medical problems that need to be fixed in an acute care hospital, but they can't go home either, because they'd fall; they're not looking after themselves; they're demented; they have behavioural issues, all those kind of things that home care has failed to adequately addressed." (Physician)

"When they look at the number of ALC patients, say, today, and it's 72 or whatever and you look at the staffing complement to go with that, people automatically assume, "Well, you have that many, 72, ALC. Why would you need this many nursing staff? You don't… It's not the same kind of care that you're providing." They don't get it. They don't get it. They don't understand that it's not … It's a different kind of care. It's an important kind of care. It's a care that they deserve." (Registered Nurse)

Theme 5: Looking Back and Moving Forward

"I think this is a cultural shift, and cultural shifts don't happen over just a couple of years, and they happen more likely over a generation or two." (Director)

"It's not something that's a start and finish thing. It is a culture. It is a very transformative change." (Patient Experience Advisor)

"I have seen a massive culture shift." (Program Manager)

Sub-Theme 1: Culture Shift

"Notice just a whole lot more positivity. When I walk down the hall there's more engagement. People will speak to you. They'll look at you. That wasn't there three years ago. It's like we're team members. We work together rather than, "Oh, I'm just in this department and you're in that department and we don't speak." It's more intercollegiality with all of us."

"Now at first they didn't like family members helping too. With that said, nowadays let's

say you have a sibling or a mom or whatever, now you can actually give that extra help and they feel more at ease because it's not just a nurse or a doctor poking that patient." (Maintenance Worker)

"Five years ago, I wasn't even sure I wanted to be around a table with these people. There was, "Why are you here, and why am I sitting beside a doctor, and an oncologist, and a frontline staff," so it was that kind of thing.Five years later, the respect both ways. They want our opinions, they want us to give our opinions, we're heard, things are implemented." (Patient Experience Advisor)

"I think, sort of like I was saying before, is the awareness, not just by us, but by staff. Like I'm loving when I'm sitting in a meeting, and a staff member will say, "Yeah, but from a patient perspective, this is what ...," and you're like, "I didn't have to say anything." They are just always thinking that way." (Patient Experience Advisor)

"Huge, huge change. Back in the day when I was at the bedside, we would say to patients, "You're going to get your bath at 10:00 today. You're going to go to physio at 11:00 today. You're going to do this. You're going to do that. It's going to be this time, that time," and now, it's not that way. It's what are your priorities today and usually for patients, that might be ... It's still small things. "I want to get my hair washed today. I'd like to have a shower today. I really like to get my teeth brushed today."
It's those smaller things that matter the most to them." (Program Manager)

"People really, really want to make a difference and see opportunities for improvement. People are committed then to partnering and working together to make those changes." (Director)

"Certainly, we don't hear in the newspaper the things that we used to hear. There's still horror stories. They still happen, but it's not as commonplace as it used to be six or seven years ago. I think we have a much better community profile than we did back then" (PFCC Lead)

"We said we are going to figure out how to translate our commitment of no decisions about an experience that affect people without those that are affected at the table, and we started down the path. Standing or holding through to that commitment and not wavering from it over five years has really helped us build the deepness and the comprehensiveness of our approach." (CEO)

"I also see a commitment with the people that are here now. People are really excited and I think people think differently." (Director)

Sub-Theme 3: Moving Forward

"It's like any change and this is a significant change in culture. It takes time and it will only be successful if you have involvement of the frontline, if their engagement ... It's making sure that the committees that we have to look at various different pieces of patient

care is making sure that we have frontline involvement on those committees that they sit on." (Program Manager)

"I think now you've got the community, the key to continuing it will be, for the this institution, will be getting the community members involved. I think that's always a struggle. Keeping community members involved so that we have community members and enough of them because you can't wear them out, right?" (Nurse Practitioner)

"I think the involvement of the patients is relatively new as well. I mean, the patients who are ready to do this … We're asking people and they're still not sure what they're getting into, and is this something I can help with? I think they feel probably intimidated many times, because they are coming into an environment that's outside of what they usually do, and so they're outsiders as it were. I think we're building a cadre of patient experience advisors, but I think that will continue to grow and evolve for another decade probably, maybe more" (Director)